DEPARTMENT OF THE NAVY
UNITED STATES FLEET FORCES COMMAND
1562 MITSCHER AVENUE SUITE 250
NORFOLK VA 23551-2487

5830
Ser N00/151
7 May 19

FINAL ENDORSEMENT on (b)(6) ltr of 27 Jul 18

From: Commander, U.S. Fleet Forces Command
To: File

Subj: COMMAND INVESTIGATION INTO THE DEATH OF ENS SARAH JOY MITCHELL, USN, AT SEA, ON 8 JULY 2018

Encl: (64) Voluntary Statement of (b)(6) dtd 1 Apr 19
(65) Voluntary Statement of (b)(6) dtd 1 Apr 19

1. I thoroughly reviewed the subject investigation and its endorsements. I approve the findings of fact, opinions, and recommendations as previously endorsed and as modified below.

2. Findings of Facts:

a. FF 312 added: On the morning of 8 July, (b)(6) was on the bridge prior to launching RIB KELLY MILLER and RIB BILLY HAMPTON. After conferring with the OOD (b)(6), (b)(6) made the decision to execute planned RIB operations. [Encl (21)]

b. FF 313 added: The OOD is charged with "the direct supervision of the ship's boats" and is responsible for "ensuring that all boat safety regulations are observed" in accordance with reference (c).

c. FF 314 added: (b)(6) was the scheduled OOD for the 0700 - 0930 watch and assumed the watch at 0700. [Encl (17), (22), (64)]

d. FF 315 added: The boat deck was given permission from (b)(6), through (b)(6) (b)(6), to load, lower, and launch RIB KELLY MILLER and RIB BILLY HAMPTON. Both RIBs were in the water at approximately 0910. [Encl (17), (21), (64)]

e. FF 316 added: (b)(6) gave trip and shove off orders to the two RIBs before breakaway and then gave them permission to load, lower, and launch when they were ready. [Encl (64)]

f. FF 317 added: (b)(6) recalls both RIBs having normal breakaways which she observed from the starboard bridgewing. [Encl (64)]

g. FF 318 added: (b)(6) observed the RIBs the entire time during their breakaways and did not see either RIB perform a donut or any other aggressive maneuvering. [Encl (64)]

h. FF 319 added: (b)(6) was on the bridge for approximately 30 minutes prior to watch relief (scheduled OOD for the 0930 - 1200 watch) and during that time he was walking around the bridge and talking to the JOOD. [Encl (17), (22), (65)]

i. FF 320 added: (b)(6) recalls both RIBs already being away from the ship when he began turnover with (b)(6), and he did not observe either RIB perform donuts in the water. [Encl (64)]

j. FF 321 added: (b)(6) left the bridge at 0944. [Encl (17)]

k. FF 322 added: Sometime between 0910 and 0948, (b)(6) and (b)(6) turned over OOD responsibilities. (b)(6) assumed duties as OOD at 0948. [Encl (17), (64), (65)]

1. FF 323 added: (b)(6) qualified as Officer of the Deck (OOD) in March 2017 onboard USS MAHAN. He completed his requalification process on 4 July 2018. [Encl (34)]

m. FF 324 added: (b)(6) supervised RIB KELLY MILLER and RIB BILLY HAMPTON complete passenger swaps before the second trip. [Encl (34)]

n. FF 325 added: (b)(6) observed RIB BILLY HAMPTON make a routine breakaway on the second trip. He eventually lost sight of RIB BILLY HAMPTON behind the superstructure. [Encl (34)]

o. FF 326 added: (b)(6) did not observe either of the RIBs perform donuts or aggressive maneuvering. [Encl (65)]

p. FF 327 added: After the RIB KELLY MILLER breakaway for the second trip, (b)(6) (b)(6) coordinated SAR training with RIB KELLY MILLER and set flight quarters for recovery, crew swap, and hot pump and relaunch of Venom 506. [Encl (34)]

q. FF 328 added: As (b)(6) instructed RIB KELLY MILLER to station on the starboard side of USS JASON DUNHAM for the SAR exercise, he heard medical emergency called over bridge to bridge. [Encl (34)]

r. FF 329 added: (b)(6) initially thought the call for medical emergency was a part of the SAR drill. He went to look for RIB KELLY MILLER over the bridge wing. He noticed that RIB KELLY MILLER was not in the designated position for the drill and that no one was in the water. [Encl (34)]

s. FF 330 added: (b)(6) ran over to the port side bridge wing to get a better view of the area where RIB BILLY HAMPTON was positioned. He observed three KAPOCs bobbing in the water. [Encl (34)]

t. FF 331 added: (b)(6) directed the BMOW to call the CO to the pilot house and informed the TAO that individuals were in the water. [Encl (34)]

3. Opinions:

a. Opinion 30 is added: Both (b)(6) and (b)(6) adhered to the standards outlined in reference (c) for the OOD. Per reference (c) the OOD is responsible for the direct supervision of the ship's boats as well as ensuring that the boats are operated safely and that all safety regulations are adhered to. Neither (b)(6) nor (b)(6) observed the RIBs performing aggressive maneuvers. Additionally, at the time of the accident, RIB KELLY MILLER was off the stern of JASON DUNHAM and the ship's superstructure was blocking (b)(6) view of RIB BILLY HAMPTON. Also at that time, (b)(6) was coordinating a SAR exercise with RIB KELLY MILLER. [FF's (312)- (331)]

4. Recommendations:

a. Recommendation 3 is disapproved. This recommendation is redundant. Qualification under NAVEDTRA 43152-L Coxswain 302 and Small Boat Officer 305 require watchstation qualification for Bow/Stem Hook 301 as a pre-requisite, and qualification for Bow/Stern Hook 301 includes completion of Fundamentals Section 102.21.

b. Recommendation 4d is disapproved. As stated by CSG-8, selection boards, particularly Chief Petty Officer selection boards, are critical to the current and future health of the Navy. The Commanding Officer should retain the discretion to dispatch members of the crew when deemed appropriate.

5. The following actions are complete:

a. Recommendations 1-Modified and 2. Administrative actions have been taken by CDS-28 against all appropriate parties. (b)(6)
(b)(6)

b. Recommendations 3a-Added and 3c-Added. Both recommendations were submitted to NETC for review and action. Specifically, CNSL submitted PQS and FLTMPS change forms requesting that RIB Coxswain COI (CIN-K-062-0625) be a pre-requisite to final qualification as a 7M RIB Coxswain, and a recommendation that SWOS review curriculum to ensure small boat fundamentals are covered to include use of centerline lifeline and proper passenger distribution during transit.

c. Recommendation 3b-Added. ATG Atlantic coordination with CSCS is complete. ATG trainers and the schoolhouse reviewed small boat operations training, to include fundamentals on use of the centerline lifeline and passenger operational risk management, are aligned.

d. Recommendation 3d-Added. CDS-28 developed a safety brief checklist for small boat operations. The list was implemented by CSG-8. CNSL is reviewing the checklist and will codify a standard checklist for the Fleet and report completion to USFF.

e. Recommendation 3e-Added. In order to increase visibility and understanding in the Fleet, CNSL released a message providing specific guidance on safe operations of small boats to all SURFLANT Commands. At the conclusion of this Command Investigation, a Fleet Advisory message that conveys lessons learned and highlights the availability of training aides and resources will be released.

f. Recommendation 4a. CNSL submitted PQS and FLTMPS forms to NETC requesting an increase in the required number of RIB Coxswain COI graduates on a boat from two to four. On 1 October 2018, FLTMPS was updated to reflect the new requirement for all ships.

g. Recommendations 4b and 4c. Both recommendations were forwarded to Naval Sea Systems Command (NAVSEA) for specific consideration as to whether Naval Ships Technical Manual (NSTM) 583 should be modified to include guidance on safe operations of small boats, to include direction on preventing tripping, factors for consideration for safe riding positions, and use of a centerline life line. With regard to Recommendation 4b, sample RIB and operational checklists are available on the ATG (Afloat Training Group) Toolbox website.

h. Recommendation 4e. By copy of this endorsement, this recommendation is forwarded to Commander, U.S. Pacific Fleet (PACFLT), requesting Helicopter Sea Combat Squadron THREE (HSC-3), as the Search and Rescue Model Manager, be directed to evaluate the continued efficacy of the Stokes Litter and determine future recommendations regarding number and stowage locations for this equipment. HSC-3 is requested to report completion to USFF as directed by PACFLT.

6. A tragic and unfortunate series of events led to Ensign Mitchell's death. While the execution of safe boat operations and incorporation of PBED may have prevented this accident, there are still several inconsistencies in guidelines in our training pipeline that should have been addressed earlier. I am satisfied with the steps CNSL and CDS-28 have taken and continue to take. All Commanders should regularly reassess the training and qualifications of personnel involved in small boat operations to ensure completion of all pre-requisites, proper implementation of PBED, and appropriate staffing and oversight of qualified personnel.

C. W. GRADY

Copy to:
PACFLT, NAVCENT, NAVSEA, NETC, CNAL, CNSL, CSG-8, CDS-28, HSC-3

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer

Date: 1 April 19

Location: U.S. FLEET FORCES

Subj: Voluntary Statement

I make the following statement freely and voluntarily:

I have been on board JDM since February 2018. I was the Navigator in July 2018 and still hold that position. I requalified as OOD in February 2018 while we were underway as ~~OOD~~ 28. My previous DIVO tour was onboard ARLINGTON.

I observed boat ops when on JDM while TAD before I formally checked in, but this was the first time as OOD. I do not recall the Ops/Intel brief from back then (October 2017).

I am part of the OOD qualification process onboard JDM. I am familiar with the standing ~~officers~~ ORDERS and the night orders. I am familiar with the Boat checklist but not as familiar with the rest of the boat bill.

I believe that we were in four-section watch in July and that I would have assumed OOD at ~~0730~~ 0700 and held it until 0930. I kept the watch while the RIBs were being launched and started turnover once they came around to on load passengers. I believe I kept it a little longer for continuity during boat ops. After I turned over, I went to the chart room.

I remember boat ops on 8 July 2018. I was on duty when boat ops started (trip 1). I do not recall which RIB entered the water first. I gave trip and shove off orders when the RIB broke away. I gave them permission to load, lower, and launch when they were ready. Someone came up from the boat deck, I do not recall who, but they came up to the ~~deck~~ PILOT HOUSE to get bridge to bridge (B2B) radios. My JOOD gave them the radios. I did not give them any direction at that time. The plan was discussed and set during OPS/Intel the night before.

The CO arrived on the bridge before the boats launched, that's what he usually did. He did not give the RIBs any specific orders. If he had done that, he probably wouldn't have done it directly because he would have gone through the bridgewing phone talker. I do not think that he gave them any orders via phone talker or otherwise.

I recall both RIBs having a normal breakaway. I was on the starboard bridgewing while they were breaking away, I drew the path of ENS Mitchell's RIB on a separate page.

I observe the RIBs the whole time they broke away. I did not see either RIB conduct a donut or other aggressive maneuvering. The turn looked normal in terms of speed and turn. There was an excitement that we got to finally go to put the small boats in the water, but I do not think they were trying to show off for the MIDN.

The CO was still on the bridge when the first trip broke away, I think he was watching the RIBs, too. (b)(6) on the bridge around 0925. I do not think he was there when the first RIB launched.

When we were doing turnover, I told (b)(6) the VBSS RIB was going to do its drill, then it would return and we would send out more MIDN and BoatO U/Is. I recall the second RIB was for safety for the first trip. Both RIBs were to conduct a second trip for training. We did not discuss specific training that the RIBs were going to do. We did not have a specific plan or maneuvers in mind for training.

As OOD, I felt that I was ensuring the safety of the RIBs while they were out there. I trusted the BoatOs. In the moment, I did not think they needed additional guidance on speed or otherwise. I did not know there was a reenlistment happening on board the second RIB (safety RIB, not the VBSS RIB). I think there were more people on board the RIBs for the second trip. If I had seen that many people onboard during the first time, I might have said something more to the boat officers.

I think the lack of knowledge about what was going on and poor planning contributed to this accident. I did not tell anyone that day that I thought there was a lack of planning. We do it better now.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 2 page(s) typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

02APR19

Date

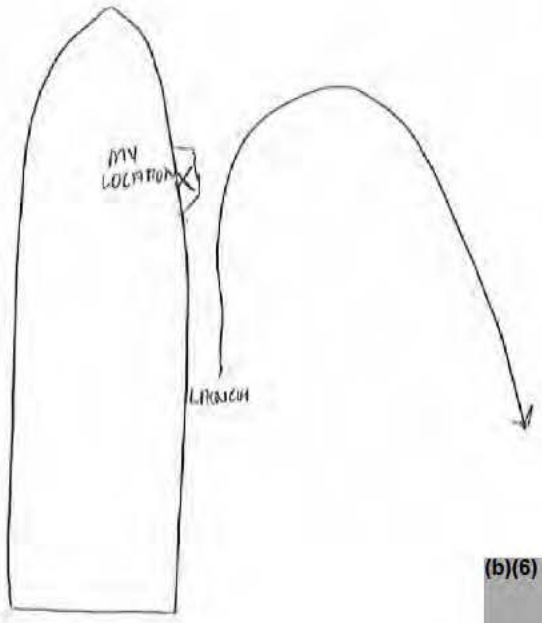
Sworn and Witnessed by (b)(6)

DEPARTMENT OF THE NAVY
VOLUNTARY STATEMENT

1. PLACE: USFF
2. DATE: 1 Apr 19

I, (b)(6) [redacted], make the following free and voluntary statement to (b)(6) [redacted], whom I know to be the Investigating officer.

I make this statement of my own free will and without any threats or promises extended to me. I fully understand that this statement is given concerning my knowledge of



(b)(6) [redacted]

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer

Date: 1 April 19

Location: U.S. FLEET FORCES

Subj: Voluntary Statement

I make the following statement freely and voluntarily:

I assumed duties as OOD right after the small boats were away. (b)(6) wanted to hold the watch until the boats were away rather than conducting turnover in the middle of the boats breaking away. I held OOD until the helicopter departed with Ms. Mitchell on 8 July 18. When I was relieved, I reviewed the deck log for discrepancies before departing the bridge.

I was not on watch when boat ops started. I do not remember which boat was lowered first because I was not OOD at that time. I did not provide a Trip and Shove-Off order before the RIB broke away as I was not the OOD for the first trips (both RIBs). I gave the break off order for the second trips for each RIB.

I am familiar with the JDM Boat Bill; I have reviewed it.

I likely got up to the bridge around 0910 or 0915 because I am supposed to arrive at my station at least 15 minutes before watch starts. I believe I ended up being on the bridge about 30 minutes prior to taking the watch. (b)(6) made the decision to hold OOD until the RIBs were away, but since the CO was on the bridge at the time we also informed him of our plan and got his approval prior to execution. During the 30 minutes of time when I was on the bridge before taking over the watch, I was walking around the bridge and talking with the JOOD, who relieves earlier than the OOD. I also watched over the bridge wing, talked with the CO and I spent the rest of the time waiting to take the watch. When conducting turnover with (b)(6) we walked all over the pilot house. We reviewed VMS, engine configuration, flight ops schedule, and the remainder of boat ops.

When I assumed the watch as OOD, both RIBs were out. Ms. Mitchell was the BoatO, I gave them the order to breakaway and carry out duties as assigned. Boats looked seaworthy, I didn't see any issues. The boat ops that I observed appeared normal. I was standing on the starboard bridgewing while I was watching the second breakaway.

The RIBs were already away from the ship for their first trip when we started turnover. I came up right after they had broken away I believe. I think they were 20-30 yards away when I arrived on the bridge. I did not see them doing anything out of the ordinary.

I do not recall BILLY HAMPTON doing donuts, I saw them come up and do the standard break away turn, which was a turn to STBD away from the ship until the RIB's heading was the reciprocal course of JDM. I did not see them do donuts before or after I took over.

CO was on the bridge at the time we were doing turnover, he stayed on the bridge through when I took the deck. He stayed up there at least through when we commenced the second trip. He left the bridge after the second trip departed to do FITREP debriefs.

I do not recall the CO being over bridge to bridge (B2B) to communicate with the RIBs prior to the incident. From turnover with (b)(6), I recall the plan being to deploy a SAR swimmer, to get MIDN rides in the RIBs and to provide training for BoatO U/Is. (b)(6) and I did not discuss a specific plan or route for the RIBs to take. I am not aware of any more specific orders being given from the bridge to the RIB. We talked with the CO about coordinating boat ops with flight ops, but that was the most involved I recall the CO being in boat ops once we were on the bridge on 8 Jul 18.

At our brief the day before, we established goals of a SAR swimmer deployment and VBSS (conducted on first trip).

I am familiar with the Boat Bill and the CO's Standing Orders: OODs are responsible for overall safety. The RIBs are an extension of the ship. I am responsible for them. I feel that I fulfilled my roll on 8 July 18. I was not solely observing the RIBs because I was also coordinating flight ops and because there were two RIBs in the water. Prior to the incident, between the two RIBs, my focus had been on the other RIB (not Ms. Mitchell's) because they were deploying their SAR swimmer for training purposes.

to the best of my abilities (b)(6)

Before turnover and right after taking the watch, I spoke with the CO about how much was going on that morning with flight quarters and boat ops being scheduled concurrently. We pushed flight quarters so that both boats could get away from the ship while the helicopter landed and took off. The CO and I discussed the safe operations of the RIBs.

I never saw any wild donuts or aggressive maneuvers on 8 July 18. The breakaway to starboard was sharp to get away from JDM. As a former First Lieutenant, I thought that was normal. If I had seen anything inappropriate or unsafe, I would have contacted the BoatO over B2B and told the RIB to return to the ship or have the BoatO change out.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 2 page(s) typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

01APR19

Date

Witnessed by (b)(6)
and sworn

DEPARTMENT OF THE NAVY
U.S. NAVAL FORCES CENTRAL COMMAND
PSC 901 BOX 1 FPO AE 09805-0001

5830
Ser N00/ 376
13 Nov 18

FOURTH ENDORSEMENT on (b)(6) ltr of 27 Jul 18

From: Commander, U.S. Naval Forces Central Command
To: Commander, U.S. Fleet Forces Command

Subj: COMMAND INVESTIGATION INTO THE DEATH OF ENS SARAH JOY MITCHELL, USN, AT SEA, ON 8 JULY 2018

1. Forwarded, concurring with the Investigating Officer's findings of fact, opinions, and recommendations, as modified by the previous endorsements and the comments below.

a. Opinion 2b-Modified. I concur with the Investigating Officer that complacency and failure to apply Planning, Briefing, Executing, and Debriefing (PBED) to training involving RIBs was a root cause of this tragic incident and not just a contributing factor.

b. Opinion 10a-Added. It cannot be understated how important PBED is to risk mitigation and successful mission completion. The planning and briefing sessions ensure that those supervising and executing the mission fully understand the risks involved. Further, proper planning and briefing allows those executing the mission to note what conditions exist at the time of the operation and modify as necessary for safe execution. The lack of PBED in relation to small boat operations on JASON DUNHAM allowed risks to accumulate and led to complacency. [FF 1-36, 47- 50, 54, 59, 77-83, 241-249]

c. Opinion 12a-Added. Outside of an emergency situation or deliberate training scenarios, there is no ostensible need for aggressive maneuvering when operating small boats. This must be consistently emphasized throughout the training and qualification process for all personnel involved in small boat operations, and during planning, briefing, executing and debriefing every boat evolution. [FF 79-83, 87, 96, 261-264, 274, 275, 281, 282, 284, 285, 287, 293-298]

d. Opinion 13a-Added. This event underscores the necessity for formality in scheduling, planning, briefing and conducting operations and training evolutions. Numerous aspects of JASON DUNHAM's boat operations on 8 July lacked the rigor of formality that is essential to professional execution. Ultimately, the Commanding Officer, backed up by the entire chain of command, is responsible and accountable for setting and reinforcing this culture of formality, and its failure on 8 July. [FF 8-18, 23-36, 48-50, 54, 59, 79, 80, 84, 85, 244, 246-248, 269, 281, 282, 287, 309-311]

e. Opinion 15a-Added. The investigation raises questions regarding the safety and adequacy of the 7 meter RHIB, including adequate seating and hand-holds for passengers and crew, which appear insufficient for the boat's max capacity of 18. [FF 265, 266, 268, 269, 279, 281, 282, 284, 285, 287, 291, 292]

f. Amplification to Recommendations 4b and 4c. I concur with Commander, Naval Surface Force Atlantic's positive endorsement of Recommendations 4b and 4c with the following amplifications. An assessment should be undertaken of the adequacy of the 7 meter RHIB to perform the wide variety of operations for which it's currently used. Careful attention should be paid to assessing the safety and adequacy of the available seating and handholds on the RHIB, as well as appropriate training and use of same. The investigation notes there are inconsistencies between the 7m RHIB Boat Information Book (BIB) and the curriculum for the Coxswain course (K-062-0625) taught by the Center for Surface Combat Systems regarding seating of passengers on boat sponsons. These inconsistencies should be assessed and corrected.

2. We must apply the numerous lessons learned from this tragic incident to ensure it is never repeated. I concur with Commander, Naval Surface Force Atlantic's intent to implement the comprehensive training and procedural corrective measures outlined in his endorsement in order to properly manage risk in a demanding environment and prevent a future recurrence.

S. A. STEARNEY

Copy to:
COMNAVSURFOR
CARSTRKGRP EIGHT
NAVSEA
NETC
ATG Atlantic
DESRON TWO EIGHT
USS JASON DUNHAM (DDG 109)
CNSL N7
(b)(6)

DEPARTMENT OF THE NAVY
COMMANDER
NAVAL SURFACE FORCE ATLANTIC
BOX 168, 1751 MORRIS STREET
NORFOLK, VIRGINIA 23511-2808

5830
Ser N01L/134
1 Oct 18

THIRD ENDORSEMENT on (b)(6) ltr of 27 Jul 18

From: Commander, Naval Surface Force Atlantic
To: Commander, U.S. Fleet Forces Command
Via: U.S. Naval Forces Central

Subj: COMMAND INVESTIGATION INTO THE DEATH OF ENS SARAH JOY MITCHELL, USN, AT SEA, ON 8 JULY 2018

1. Forwarded, concurring with the Investigating Officer's findings of fact, opinions, and recommendations, as modified by the previous endorsements and as below.

2. Changes to Recommendations.

a. On page one of the Command Investigation (CI), reference (b) is corrected to "S9008-GV-BIB-010 BIB (Boat Information Book) on 7M RIBs".

b. Added Recommendation 3.e. (CDS-28 First Endorsement, para 1.j., page 43) is modified to note that updated learning guides and training materials available on the Afloat Training Group (ATG) Atlantic toolbox website already address Coxswain fundamentals. In order to increase visibility and understanding in the fleet, Commander, Naval Surface Force Atlantic (CNSL) will issue a Fleet Advisory Message, discussed in further detail below, that will convey lessons learned from this CI as well as highlight the availability of training aides and resources. As Commander, U.S. Naval Surface Forces ordered a safety standdown after the subject incident, which was completed on 31 July 2018, I do not feel an additional safety standdown is necessary. However, the Fleet Advisory Message will require surface units to conduct an administrative review of the small boat programs and qualification process.

3. By copy of this endorsement, I direct the following:

a. ATG Atlantic, in coordination with CNSL Assistant Chief of Staff for Training and Readiness (N7), is directed to take recommendations 3.b. (CDS-28 First Endorsement, para 1.g., page 43) and 4.b. (CI, page 39) for action. Specifically, with regard to recommendation 4.b., ATG Atlantic is directed to ensure sample RIB operational briefs and checklists are available on the ATG Toolbox website. Report completion to CNSL N7 every 30 days until action is complete.

b. CNSL N7, in coordination with Carrier Strike Group EIGHT, is directed to take recommendation 3.d. (CDS-28 First Endorsement, para 1.i., page 43), for action. Additionally, in support of recommendation 4.a (CI, page 39), CNSL N7 is directed to (1) submit a PQS feedback form to Naval Education and Training Command (NETC) requesting that the RIB Coxswain COI (CIN K-062-0625) be a prerequisite to final qualification as a 7M RIB Coxswain and (2) submit a FLTMPS change request to increase the required number of RIB Coxswain COI graduates from two to four for all surface ships (excluding Patrol Craft and Minesweepers). In support of recommendations 4.b., 4.c., and 4.f (CI, page 39), CNSL N7 is also directed to draft a Fleet Advisory Message

no later than 01 November 2018 that provides guidance to Coxswains and Boat Officers on safe operation of small boats – to include preventing the 'tripping' phenomena; factors for consideration for safe riding positions and use of a centerline life line; and application of the Plan, Brief, Execute, Debrief (PBED) process with respect to certain small boat operations. The Fleet Advisory Message should also reaffirm current instruction that provides the Boat Officer the authority to deploy a rescue swimmer in the event of an actual emergency.

4. Recommendations 3.a. and 4.a. are positively endorsed and recommended for forwarding to NETC for review and action, as supplemented by the above.

5. Recommendations 4.b. and 4.c. are positively endorsed and recommended for forwarding to Naval Sea Systems Command (NAVSEA) for specific consideration as to whether Naval Ships Technical Manual (NSTM) 583 should be modified to include guidance on safe operation of small boats – to include preventing the 'tripping' phenomena – and factors for consideration for safe riding positions and use of a centerline life line.

6. CNSL N7 is assigned lead for tracking actions above and reporting progress to CNSL Chief of Staff every 30 days until complete.

J. A. WILSON, JR

Copy to:
COMNAVSURFOR
CARSTRKGRP EIGHT
NAVSEA
NETC
ATG Atlantic
DESRON TWO EIGHT
USS JASON DUNHAM (DDG 109)
CNSL N7
(b)(6)

DEPARTMENT OF THE NAVY
COMMANDER CARRIER STRIKE GROUP EIGHT
UNIT 200297 BOX 1
FPO AE 09502

5830
Ser N02/131
5 Sep 18

SECOND ENDORSEMENT on (b)(6) ltr of 27 Jul 18

From: Commander, Carrier Strike Group EIGHT
To: Commander, U.S. Fleet Forces Command
Via: (1) Commander, Naval Surface Forces Atlantic
(2) Commander, U.S. Fifth Fleet

Subj: COMMAND INVESTIGATION INTO THE DEATH OF ENS SARAH JOY MITCHELL, USN, AT SEA, ON 8 JULY 2018

Encl: (62) (b)(6) ltr of 17 Jul 18 w/end
(63) COMCARSTRKGRU EIGHT ltr 5830 Ser N02/121 of 18 Jul 18

1. Subject investigation is forwarded with the addition of enclosures (62)–(63). Enclosure (62) is the investigating officer's line of duty determination relating to ENS Sarah Joy Mitchell, USN, and enclosure (63) is my final action on same. ENS Mitchell's tragic and untimely death occurred while she was in the line of duty and not due to her misconduct.

2. After a thorough review of the report of investigation and the first endorsement thereon, I concur with the investigating officer's findings of fact, opinions, and recommendations as modified by the first endorsement and the comments below.

a. Opinions 4a, 23—Do Not Concur. Selection boards, particularly Chief Petty Officer selection boards, are critical to the current and future health of the Navy. Currently deployed Command Master Chiefs from the fleet must be represented on the boards building the Navy's CPO Mess. The mission requires operational commands to function as a team of teams with leadership in depth which allows them to maintain maximum effectiveness even when individual teammates are absent. The Commanding Officer must maintain the prerogative to dispatch members of his crew when he deems appropriate.

b. Opinions 19b—Concur and Supplement. (b)(6) executed two donut turns without incident during the first trip of RHIB BILLY HAMPTON, and ENS Mitchell and (b)(6) (b)(6) planned to do the same training during the second trip. As such, (b)(6) had ENS Mitchell's implied, if not actual, authority to execute such turns during trip two. (b)(6) (b)(6) states he did not like the turn executed during trip one but did not mention it because he had no radio. However, RHIB BILLY HAMPTON returned to JASON DUNHAM between trips one and two, giving (b)(6) the opportunity to correct (b)(6) (b)(6) did not provide forcible backup. [FF 48–50, 62, 75–76, 80]

3. Action. I direct Commander, Destroyer Squadron TWO EIGHT to develop the safety brief checklist for small boat operations described in Recommendation 3d and implement its use in all

DESRON 28 units within 30 days. The checklist will be shared with USS NORMANDY (CG 60) and USS HARRY S. TRUMAN (CVN 75) and implemented as amended by their respective Commanding Officers. I will forward the checklist and report on implementation in 45 days.

E. H. BLACK III

17 Jul 18

From: (b)(6)
To: Commander, Destroyer Squadron TWO EIGHT

Subj: LINE OF DUTY DETERMINATION IN THE CASE OF ENS SARAH JOY MITCHELL, USN

Ref: (a) JAGINST 5800.7F

Encl: (1) Appointing Order dtd 9 Jul 18
(2) JASON DUNHAM ship's deck log of 9 Jul 18
(3) JASON DUNHAM's Medical records of ENS Mitchell dtd 8 Jul 18
(4) Voluntary Statement of (b)(6) dtd 13 Jul 18
(5) Voluntary Statement of (b)(6) dtd 13 Jul 18
(6) Voluntary Statement of (b)(6) dtd 13 Jul 18
(7) Voluntary Statement of (b)(6) dtd 13 Jul 18
(8) Voluntary Statement of (b)(6) of 13 Jul 18
(9) Voluntary Statement of (b)(6) dtd 13 Jul 18
(10) Voluntary Statement of (b)(6) dtd 13 Jul 18
(11) Voluntary Statement of (b)(6) dtd 13 Jul 18
(12) Voluntary Statement of (b)(6) dtd 12 Jul 18
(13) Voluntary Statement of (b)(6) dtd 12 Jul 18
(14) Voluntary Statement of (b)(6) dtd 12 Jul 18
(15) Voluntary Statement of (b)(6) dtd 12 Jul 18
(16) Voluntary Statement of (b)(6) dtd 13 Jul 18

1. This reports completion of the line of duty inquiry conducted in accordance with reference (a) into the death of ENS Sarah Joy Mitchell, USN a 23-year-old female Naval Officer assigned to USS JASON DUNHAM (DDG 109) for approximately one year.

2. Personnel contacted: Nine of the eleven onboard Rigid Hull Inflatable Boat (RHIB) call sign BILLY HAMPTON Serial 7MRB0720 with ENS Mitchell on 8 July 2018. Crew: (b)(6) (b)(6) Coxswain; (b)(6) Boat Engineer; (b)(6) Search and Rescue (SAR) swimmer. Passengers: (b)(6) Boat Officer Under Instruction; (b)(6) (b)(6) Boat Officer Under Instruction; (b)(6) Boat Engineer Under Instruction; (b)(6) passenger; (b)(6) passenger; (b)(6) (b)(6) passenger; (b)(6) passenger. Other relevant personnel: (b)(6) (b)(6) Boat Officer RHIB KELLY MILLER; (b)(6) Independent Duty Corpsman; (b)(6) Rescue Swimmer. Not interviewed: (b)(6) unavailable due to emergency leave.

3. Materials Reviewed: Voluntary statements from all witnesses contacted, the deck log of USS JASON DUNHAM (DDG 109), and ENS Mitchell's medical record from her treatment on board JASON DUNHAM on 8 July 2018.

4. Summary of Findings: USS JASON DUNHAM (DDG 109) was conducting routine operations on 8 July 2018, in the Red Sea, which included small boat operations for the purpose of training and maintaining crew qualifications as prescribed in the Plan of the Day (POD). Conditions reported optimal for boat operations, Sea State reported 1-2 feet winds 5-7 knots.

At approximately 0910 and 0924 on 8 July 2018, two Rigid Hull Inflatable Boats (RHIBs) with call signs KELLY MILLER and BILLY HAMPTON were launched. ENS Sarah Joy Mitchell, USN was on Active Duty in a duty-status as the Boat Officer of the RHIB BILLY HAMPTON. RHIB BILLY HAMPTON conducted two trips that day with the same crew but different passengers for each trip. On the second trip, RHIB BILLY HAMPTON had eleven personnel on board, including a Boat Officer, Coxswain, Search and Rescue (SAR) swimmer, Boat Engineer, two Boat Officers (under instruction U/I), one Boat Engineer (under instruction U/I), and four Midshipmen.

On the second trip RHIB BILLY HAMPTON traveled astern of the JASON DUNHAM, heading toward the port quarter where it resumed training operations. Within minutes of beginning training, at approximately 1021, four personnel were ejected from the RHIB BILLY HAMPTON during the execution of a hard turn to port. The fifth, the SAR swimmer, (b)(6) (b)(6) deployed himself immediately by letting go of the RHIB in the turn. The four personnel cleared to starboard, ENS Mitchell passed directly under the RHIB being struck on the head by the stern drive, which inflicted severe head trauma. (b)(6) focused on assisting ENS Mitchell, who he observed injured and face down in the water. (b)(6) rolled ENS Mitchell onto her back and towed her back to RHIB BILLY HAMPTON. Once ENS Mitchell was on board the RHIB, (b)(6) immediately began treating ENS Mitchell who had suffered severe head trauma. RHIB KELLY MILLER, which had been conducting training separately, ceased its training operations to assist RHIB BILLY HAMPTON. After RHIB KELLY MILLER arrived on station, it came alongside RHIB BILLY HAMPTON. RHIB BILLY HAMPTON was not operational; its propeller had ENS Mitchell's life jacket wrapped around it. Therefore, the RHIB crews transferred ENS Mitchell to RHIB KELLY MILLER to return her immediately to JASON DUNHAM for medical treatment.

During the transit back to JASON DUNHAM, (b)(6) dressed ENS Mitchell's wounds before performing chest compressions and rescue breathing on her. After reaching JASON DUNHAM, ENS Mitchell was lifted on board via a litter where medical treatment, including chest compressions and rescue breathing, continued as she was transferred to the ship's helicopter for medical evacuation. The helicopter departed USS JASON DUNHAM (DDG 109) at approximately 1130. ENS Mitchell was pronounced deceased at 1245 by medical staff at Prince Hashem bin Abdullah II hospital in Aqaba, Jordan.

5. Recommendation: I recommend that the death of ENS Sarah Joy Mitchell, USN be found in the line of duty, not due to her own misconduct.

(b)(6)

DEPARTMENT OF THE NAVY
COMMANDER DESTROYER SQUADRON TWO EIGHT
UNIT 200299 BOX 1
FPO AE 09502

5830
Ser N00/109
9 Jul 18

From: Commander, Destroyer Squadron TWO EIGHT
To: (b)(6)

Subj: COMMAND INVESTIGATION INTO THE DEATH OF ENS SARAH JOY MITCHELL, USN, AT SEA, ON 8 JULY 2018

Ref: (a) JAGINST 5800.7F, Chapter II

1. Pursuant to reference (a), I appoint you to investigate the facts and circumstances surrounding the 8 July 2018 death of ENS Sarah Joy Mitchell, USN, USS JASON DUNHAM (DDG 109).

2. Investigate the cause of the incident and any fault, neglect, or responsibility therefore. Specifically consider whether death occurred in the line of duty as described in reference (a), Part E.

3. Report your findings of fact, opinions, and recommendations in letter form no later than 28 July 2018, unless an extension of time is granted by me for good cause.

4. Before beginning your investigation, read reference (a). Note, at no time shall your investigation interfere with any ongoing law enforcement actions or safety investigations. The Naval Criminal Investigative Service point of contact is (b)(6) (NCIS), (b)(6)

5. Your legal advisor for the investigation is (b)(6) (b)(6) Consult (b)(6) before beginning the investigation and throughout the process.

K. M. KENNEDY

Copy to:
(b)(6)

Enclosure (1)
Enclosure (62)

REPORT SYMBOL: OPNAV 3100-10

IF CLASSIFIED STAMP SECURITY MARKING HERE

SHIP'S DECK LOG SHEET

USE BLACK INK TO FILL IN THIS LOG

SHIP TYPE	HULL NUMBER	YEAR	MONTH	ZONE	DAY		CLASS	HANDL
D A	DDG 109	8	07	C	09	E	U	1
1 2	3 4 5 - 7	12	13 - 14	15	16 - 17	22	78	79

USS JASON DUNHAM

AT / PASSAGE FROM REDSEA

TO

POSITION	ZONE	TIME
0800		
L 27°22.0N		BY 2
λ 034°49.4E		BY 2

POSITION	ZONE	TIME
1200		
L		BY
λ		BY

POSITION	ZONE	TIME
2000		
L		BY
λ		BY

LEGEND
1 - CELESTIAL
2 - ELECTRONIC
3 - VISUAL
4 - D.R.

TIME	ORDER	CSE	SPEED	DEPTH	RECORD OF ALL EVENTS OF THE DAY
18 - 21	23 - 29	30 - 32	33 - 36	37 - 40	41 77
					0330-0700 (CIWD)
					(b)(6)
					0700-0730
0655					ASSUMED THE WATCH. UIW AS BEFORE
0716	R15°R	270			
	SA²		10		
0723	STDY	270			268° DFGMC
0732					FLIGHT QUARTERS
0735					2AGTM PLACED ONLINE
0739					RECEIVED DRAFT REPORT. FWD 21' 6", AFT 21' 1",
0740					MEAN 21' 4", DISPLACEMENT 9,100 TONS.
					RED DECK
0743					AMBER DECK
					RED DECK
	R10°R	090			
0747	SASG	350			340 DFGMC
0801					AMBER DECK
					CO IS ON THE BRIDGE
0802					GREEN DECK
0803					RED DECK
0806	L10°R	190			
0806					SECURE FROM FLIGHT QUARTERS
0809					CO IS OFF THE BRIDGE
0936	RSR	355			345 DFGMC
0814	AA'		5		
0815	AA'		3		
0819					MAN THE BOAT DECK
0954					RHIB IS AT THE RAIL
					RECEIVED BOAT REPORT

REPORT SYMBOL: OPNAV 3100-10

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SHIP TYPE	HULL NUMBER	YEAR	MONTH	ZONE	DAY		USS	CLASS	HANDL
DA	DDG 109	8	07	C	08	E	JASON DUNHAM	U	

AT / PASSAGE FROM RED SEA

TO

POSITION	ZONE	TIME	POSITION	ZONE	TIME	POSITION	ZONE	TIME	LEGEND
0800			1200			2000			1 - CELESTIAL
L _____		BY ____	L _____		BY ____	L _____		BY ____	2 - ELECTRONIC
λ _____		BY ____	λ _____		BY ____	λ _____		BY ____	3 - VISUAL
									4 - D.R.

TIME	ORDER	CSE	SPEED	DEPTH	RECORD OF ALL EVENTS OF THE DAY
18 - 21	23 - 29	30 - 32	33 - 36	37 - 40	41 77
					0700-0930 (CONT'D)
0857				(b)(6)	HAS THE CONN
0859					CO IS ON THE BRIDGE
0910					RHIB IS IN THE WATER
0925					RHIB IS AT THE RAIL
0928					RECEIVED MUSTER REPORT
0930					RHIBS IS IN THE WATER
					SHIP IS ENTERING A DAMAGE CONTROL TRAINING TEAM ENVIRONMENT
0942	AA1		5		
0944					CO IS OFF THE BRIDGE
0948				(b)(6)	HAS THE DECK
				(b)(6)	
					0930 - 1200
0948					ASSUMED THE WATCH UNDERWAY AS BEFORE
1005				(b)(6)	BOARDED RHIB
1010					TOXIC GAS DRILL
1015					SET FLIGHT QUARTERS
1018					RHIBS AWAY & PAX IN BILL HAMPTON
1020					CO IS ~~OFF~~ ON THE BRIDGE
	R2R				
1021					MAN OVERBOARD REPORTED FROM RHIB 27°24.2N, 034°41.8E
1022	RAMID				
	LSR				
1023	LFR				
	AA2			10	
1026	SASC	240			
	AA1	5			
					MEDICAL EMERGENCY REPORTED IN RHIB ACTUAL CASUALTY
1030					HEAD INJURY REPORTED SAR SWIMMER PERFORMING CPR

(b)(6)

SHIP'S DECK LOG SHEET

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USE BLACK INK TO FILL IN THIS LOG

SHIP TYPE	HULL NUMBER	YEAR	MONTH	ZONE	DAY		CLASS	HANDL
DA	DDG 109	8	07	C	08	E	U	/

USS JASON DUNHAM

AT / PASSAGE FROM RED SEA

TO

POSITION	ZONE	TIME	POSITION	ZONE	TIME	POSITION	ZONE	TIME	LEGEND
0800			1200			2000			1 - CELESTIAL
L		BY	L		BY	L		BY	2 - ELECTRONIC
λ		BY	λ		BY	λ		BY	3 - VISUAL
									4 - D.R.

TIME	ORDER	CSE	SPEED	DEPTH	RECORD OF ALL EVENTS OF THE DAY
18 - 21	23 - 29	30 - 32	33 - 36	37 - 40	41 77
/					0930-1200 CONTD
1037				SET	RIVER CITY 2
1039				GREEN	DECK
1041				AMBER	DECK
/				CO	IS OFF THE BRIDGE
1043				~~PER~~	MEDICAL EMERGENCY IN ROUTE TO MAIN MEDICAL
/				RED	DECK
1045				MEDICAL	EMERGENCY IN MAIN MEDICAL
/				PLACED	UCHT AT SEA MODE
1056				RED	DECK
1101				CO IS	ON THE BRIDGE
1105				CO IS	OFF THE BRIDGE
1110				PLACED	UCHT IN TRANSIT MODE
1114				LAT AND LONG TO SAFAGA HOSPITAL 26°14.0N	
/				034°24.0E	
1117				LAT AND LONG TO AKIBA HOSPITAL 29°53N 035°59E	
1119				AMBER	DECK
/				LAT AND LONG TO AKIBA HOSPITAL 29°53.1N	
/				035°00.6E	
1125	CR	000			
/	CR	300			
1126				HELO READY TO ~~&~~ RECIEVE PATIENT. PATIENT IN	
/				ROUTE FROM MAIN MEDICAL TO HELO	
/	SAG	326			
/	SAG	266		265 OFGMC	
1129				PATIENT HAS BEEN LOADED INTO HELO	
1132				AMBER	DECK
1133				GREEN	DECK. HELO AWAY WITH PATIENT / HM2 ARCILA KING
/				RED	DECK
1138				SECURED FROM FLIGHT QUARTERS	
1141	RSR	348			

OPNAV 3100/99 (Rev. 11/2006)
S/N 0197LF1293300

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Enclosure (62)

SHIP'S DECK LOG SHEET

REPORT SYMBOL: OPNAV 3100-10
IF CLASSIFIED STAMP SECURITY MARKING HERE

USE BLACK INK TO FILL IN THIS LOG

SHIP TYPE	HULL NUMBER	YEAR	MONTH	ZONE	DAY		CLASS	HANDL
DA	006	8	07	C	08	E	U	/
1 2	3 4	5 - 7	12	13 - 14	15	16 - 17	22	78 79

USS JASON DUNHAM

AT / PASSAGE FROM RED SEA

TO

POSITION	ZONE	TIME
0800		
L		BY
λ		BY

POSITION	ZONE	TIME
1200		
L 27°22.8N		BY 2
λ 034°41.0E		BY 2

POSITION	ZONE	TIME
2000		
L		BY
λ		BY

LEGEND
1 - CELESTIAL
2 - ELECTRONIC
3 - VISUAL
4 - D.R.

TIME	ORDER	CSE	SPEED	DEPTH	RECORD OF ALL EVENTS OF THE DAY
18 - 21	23 - 29	30 - 32	33 - 36	37 - 40	41 77
					0930-1200 (cont'd)
1141					SECURE FROM MEDICAL EMERGENCY. SECURE FROM OCTT ENVIRONMENT
1142	AA1		3		
1147	AA1		5		
1200					SET: DRIFT 164°T @1.0 KTS
1200					(b)(6) HAS THE DECK
(b)(6)					x (b)(6)
					x
					1200-1430
1201					ASSUMED THE WATCH. U/W AS BEFORE
1202	LSR	180			
1209	STOY	180		178°OFFSC	
					(b)(6) HAS THE CONN
1139					KELLY MILLER ORDERED TO COME ALONGSIDE FOR RELIEVER
1147					KELLY MILLER/ BILLY HAMPTON SECURED FOR SEA
1220	RSR	000			
1226	STOY	000		358°OFFSC	
	AA2		10		
1244	AA2		12		
1247					(b)(6) HAS THE CONN.
1303					(b)(6) HAS THE CONN
1317	RSR	030			
1319	STOY	030		021°	OFFSC
1328	RSR	040			
1329	STOY	040		031°	OFFSC
1331	CR	045			
1332	STOY	045		036	OFFSC
1335	CR	050			
	STOY	050		041°	OFFSC

SHIP'S DECK LOG SHEET

REPORT SYMBOL: OPNAV 3100-10

IF CLASSIFIED STAMP SECURITY MARKING HERE

USE BLACK INK TO FILL IN THIS LOG

SHIP TYPE	HULL NUMBER	YEAR	MONTH	ZONE	DAY		CLASS	HANDL
DA	DDG 109	9	07	C	08	E	U	/

USS JASON DUNHAM

AT / PASSAGE FROM RED SEA

TO

POSITION	ZONE	TIME
0800		
L		BY
λ		BY

POSITION	ZONE	TIME
1200		
L		BY
λ		BY

POSITION	ZONE	TIME
2000		
L		BY
λ		BY

LEGEND
1 - CELESTIAL
2 - ELECTRONIC
3 - VISUAL
4 - D.R.

TIME	ORDER	CSE	SPEED	DEPTH	RECORD OF ALL EVENTS OF THE DAY
18 - 21	23 - 29	30 - 32	33 - 36	37 - 40	41 77
					1200-1480 (cont'd)
1337	CR	055			
1338	STOT	055			046°DFGMC
1348	RSR	070			HELO REPORTED LEAVING HOSPITAL
1350	SO76				DFGMC 066°M
1354					(b)(6) HAS THE CONN
1404	RIOR	086			
1406	SO86				DFGMC 084°M
1407	AAI		5		
1420					(b)(6) HAS THE DECK
					(b)(6)
					1430-1700
1422					ASSUMED THE WATCH O/W AS BEFORE
1454					(b)(6) HAS THE CONN
1457					(b)(6) HAS THE CONN
1500					SET ⅓ DRIFT 252° T @ 5KTS
1508					(b)(6) HAS THE CONN
1513	RFR	240			
1514					SET FLIGHT QUARTERS RECOVERY VENOM 506
1518		240			235 DFGMC
	LFR	180			
1525		180			176 DFGMC ; GREEN DECK
1542					AMBER DECK
1543					RED DECK
1545	AA1		3		
1604					CO IS ON THE BRIDGE, CME TO TRAIL SHAFT
1607					CO IS OFF THE BRIDGE
1621					AMBER DECK
1629					(b)(6) HAS THE CONN

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S/N 0197LF1293300

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(b)(6)

[redacted]

(b)(6)

[redacted]

(b)(6)

[redacted]

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer, (b)(6) Legal Advisor

Date: 12 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

I typed up a statement regarding the events of 8 July 2018 on 10 July 2018 knowing that an after-action report would be required for the search and rescue (SAR) event and anticipating an investigation. I have voluntarily provided the investigating officer a copy of this statement and adopt it as my statement together with the additional information provided here.

On 8 July 2018, ~~C~~ (b)(6) division was standing quarters midships around 0815 during underway time. 1st Lieutenant walked by and asked if I'd heard about small boat operations today. He said that we had a lot of ~~small boat operations~~ BOAT OFFICER qualifications that we needed to get done.

(b)(6) and I discussed who would be in which RHIB. He took the VBSS RHIB. I did not participate in a brief that morning and I was not on a watchbill to the best of my knowledge. SAR swimmers are not part of the VBSS team, but rather embark to support.

We launched RHIB Billy Hampton first, ~~I think~~. We loaded several passengers, this was our first set of passengers for the day. But the crew was the same for each set of passengers. Made some distance from the ship, did a reenlistment FOR (b)(6) (boat Engineer) ~~and~~ WITH AUXO. Our mission was to do Boat Officer qualifications while RHIB Kelly Miller did VBSS.

After the reenlistment, ENS Mitchell made the request over the radio for us to get permission to do SAR training, which included saying, "Hero, Billy Hampton, request permission to conduct boat officer training including deployment of the SAR Swimmer." After about five minutes, permission was granted. We were given permission so long as we stayed off the port quarter (our assigned station). ENS Mitchell asked who wants to be a survivor. (b)(6) volunteered. ENS Mitchell and I discussed whether or not he should keep his KAPOC on because of the MOBI, which would alert on the ship. Our past practice (at least two times) was for the survivor to take the KAPOC off before going in the water. I asked (b)(6) whether or not he was a good swimmer. He said that he was okay. ENS Mitchell and I talked about whether or not he should keep the KAPOC on. ENS Mitchell was going to call the bridge to see if she could deploy the survivor without the KAPOC and I told her that we had not used one in the previous practices. She acknowledged. JASON DUNHAM requested the survivor name; (b)(6) (b)(6) name was passed over the radio back to them. I stated that I wanted to to be in the water before anyone else, but (b)(6) kind of cannon-balled in the water first. He had already removed his lifejacket. SAR training was completed with his recovery. RHIB Billy Hampton returned to JASON DUNHAM shortly thereafter.

VERY QUICKLY WAS DEPLOYED BY ENS MITCHELL,

ALONG WITH THE REST OF THE PASSENGERS,

(b)(6) and the other midshipmen disembarked RHIB Billy Hampton and four different midshipmen ~~got onboard~~. AND OTHER PASSENGERS GOT ONBOARD.

FOR RHIB OPERATIONS

Demeanor of the RHIB ride was that it was the perfect seas ~~to carve up with the RHIB~~. Sun was shining and seas were flat. The coxswains routinely operate the RHIB up to its capabilities. This is normal based on my experience and my conversations with other people who are familiar with RHIB operations. Our demeanor was certainly that we were having a good time. We were happy to be off the ship for the first time in a little while, having been underway for a while.

No competition between the RHIBs, they were operating in separate areas.

To add to what I wrote in my statement about recovering the survivors from RHIB Billy Hampton, when I first saw ENS Mitchell, her injuries were too significant to recognize her. Once I got her in the RHIB, and while doing a patient assessment, I found a pulse by placing two fingers on the carotid. I yelled out that she was breathing, which was incorrect. I wanted to communicate that she was still alive. She had a fast, weak pulse.

(b)(6) assumed the position of boat officer as the ranking person present. (b)(6) also stepped up.

DOES NOT HAVE WE HAVE

The use of the Stokes Litter shocked me. It ~~has not~~ floatation attached to it and never practiced with it for overboard situations (outside of its design). I think that the Reeves Sleeve should have been configured for horizontal raising and lowering. I did not look up until she was being raised, so from my perspective it was unclear who was in charge of the recovery process to JASON DUNHAM. I HAVE HEARD FROM AN EYE-WITNESS, (b)(6) THAT DUE TO THE SPEED OF THE HOIST AND VERTICAL ORIENTATION, SHE WAS INADVERTENTLY SLAMMED ON THE DECK WHEN SHE CAME UP AND OVER.

SAR and deck operations train together – the two processes work hand in hand. This scenario has never been covered in ATG training. I see a blind spot in not covering getting a victim from a RHIB to a Navy vessel. ~~I've never had a discussion, training, or briefing on someone being ejected from a RHIB that was conducting small boat operations.~~ AN EJECTION FROM A RHIB, AND SUBSEQUENT RECOVERY FROM THE WATER, FALLS UNDER SAR TACTICS TRAINING, AND IS IN PRINCIPLE NO DIFFERENT FROM ANY OTHER METHOD OF ENTRY. SINCE NO TWO SCENARIOS ARE THE SAME, AND SWIMMERS ARE TRAINED TO THINK ON THEIR FEET, SPECIFIED TRAINING ON "PASSENGER EJECTED FROM RHIB" MAKES NO SENSE FROM A SAR PERSPECTIVE.

Weight distribution and number of people in the RHIB: weight limits were adhered to and personnel were appropriately distributed but impacts ship handling and may have been a contributing factor to how the RHIB handled. I recall (SEEM) the RHIB shifting from port to starboard, BUT RECOLLECTION OF THE PRECEDING 30 SECONDS ISN'T CLEAR. THERE WAS DEFINITELY SHIFTING AND CHANGES IN VECTOR AND INERTIA.

I participated in the previous week's training. No one went in the water then. We did not conduct SAR training.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 2 page(s) typed by (b)(6). I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

13JUL18

Date

Witnessed by (b)(6)

Incident of 08JUL18
Small boat operations fatality
Red Sea

The following is my account of the events of 08JUL18.

I (b)(6) was the SAR swimmer in RHIB Billy Hampton, along with MM2 Illig as Boat Engineer, (b)(6) (b)(6) as Coxswain, and ENS Mitchell as Boat Officer. The RHIB had several passengers onboard. I was positioned in the bow, starboard side, as the forward-most passenger. Weather conditions were ideal. Just before departing the ship I had taken the Level A Medical Kit, but no SAR Medevac Litter was onboard.

While in a turning maneuver, a sudden jolt ejected four passengers on the starboard side. I later discovered that (b)(6) was the only starboard passenger to retain his seat on the sponson. Being accustomed to the capabilities of the RHIB, I attempted to ride out the maneuver; however, as I saw passengers become airborne, I loosened my grip late in the turn, got tossed, and began immediate recovery procedures. My thought process was "they're in the water, so I'm in the water." Whether or not I could have held on through the remainder of the turn is an open question, but my entering the water was a conscious, split-second decision. As a consequence, there was considerable separation between the group of four survivors and myself. I estimate the distance from the RHIB to me at no more than 5 yards, and from me to the survivors at no more than 20 yards.

Entering the water without my fins was a tactical error, hampering my ability to make time over distance. In addition, my snorkel had detached from my mask. Although my mask was tied to my harness, upon noticing the missing snorkel I discarded it and swam immediately toward the survivors.

As I approached, I saw that three of them were clustered together, while the one closest to me was floating face down. She had no flotation and was surrounded by a cloud of blood, indicating severe injuries. I turned her over into a cross-chest carry and began towing toward Billy Hampton while assessing the injuries, which included severe lacerations to the face and skull, a hinged cranium, and visible brain matter. I proceeded with immediate extraction, calling and signaling Billy Hampton for pickup. I was unaware at that time that they were DIW. SAR Procedures call for rescue breaths to be given while waiting for pickup, but given the deformation of the face, mouth-to-mouth breaths were impossible. I continued to swim with the patient in tow and call for pickup.

At this time, still some 10 yards from Billy Hampton, the other RHIB, Kelly Miller, arrived on scene. (b)(6) (b)(6), who was Kelly Miller's SAR swimmer, called out (b)(6) and signaled "request assistance of additional rescue swimmer." I signaled back the same in the affirmative, and (b)(6) deployed on the far side, from my vantage point, of the three remaining survivors.

Once within throwing distance, I called for Billy Hampton to heave a line and was pulled alongside by (b)(6) off the port bow. With the help of (b)(6) I extracted the patient from the water.

As soon as she was aboard, I turned toward the remaining survivors with the intention of continuing in-water rescue. This was another tactical error. Given that the other swimmer had been deployed, remaining with the medical casualty was the right call. I can only attribute this decision to a lack of clear thinking. Practical in-water SAR training never includes dual swimmer scenarios and only concludes upon the extraction of all survivors. I reverted too strictly to my training and failed to adapt to the

situation. This decision cost me approximately 20 seconds of patient assessment and treatment, as it took that long to realize the error and return to the RHIB at the order of (b)(6) and (b)(6)

Once I was in the RHIB I immediately began patient assessment. Simultaneously, Kelly Miller arrived along starboard side. I checked for vitals and detected no breathing, but had a weak and rapid pulse on the carotid artery. I made this known and a decision was quickly reached to transfer the patient to the working RHIB for evac. To the best of our ability, care was taken to stabilize the head and spine. I took the Level A Medical Kit from Billy Hampton and brought it with me to Kelly Miller. We then left the initial scene and I continued treatment.

In accordance with the MARCH algorithm, major hemorrhages and life threatening injuries are to be treated first. I called for saline solution, gauze, and a 6" trauma dressing from the kit. I assigned (b)(6) (b)(6) to keep the patient's head steady and in alignment while in transit. Given the circumstances and the primacy of time I chose not don BSI and accepted the risk. I doused all facial and exterior cranial wounds with saline with the intention of wrapping them with gauze and dressing. The relevant injury was the cranial wound. The skull was split and hinged revealing the mass of the brain, which was apparently still whole, although dislodged, with the left hemisphere visible. The importance of this injury far exceeded that of the facial lacerations, deep though they were, but proper treatment exceeded the capabilities of my medical knowledge, or that of the Level A Medical Kit. I can't stress enough the severity of this injury. I decided that the best option was to keep the head intact. Taking extreme care to not disturb the brain, I closed the skull and wrapped it with the 6" trauma dressing. A rapid assessment of the limbs and torso revealed bruising on the chest but no hemorrhages or pooling blood. The mechanism and bodily location of injury were obvious—the head had passed through the propellers. At this time I reassessed vitals and found no pulse, no breathing. I immediately began chest compressions and called for a breathing mask.

I was concerned that, given the injuries to the patient's mouth, breaths would be impractical even with the mask. At the end of the first 30 compressions, I quickly assessed the mouth and attempted a jaw thrust to clear the airway. The jaw was broken in numerous places and lacked integrity. I looked in the mouth for loose objects and saw none, though I couldn't be sure. Finger sweeps are not recommended due to the possibility of lodging unseen objects further into the throat. Likewise, rescue breaths with loose objects present can do the same thing. I decided to proceed with breaths using the mask as normal.

I performed six full cycles of CPR, but the breaths were only intermittently successful due to the difficulty of achieving a proper air seal around the facial wounds. I then abandoned the breaths in favor of consistent chest compressions, which I continued as we came alongside the USS Jason Dunham. This decision was reinforced when, in a moment of doubt, I grabbed the mask to continue breaths and someone from the boat deck (who I have heard but not confirmed was (b)(6)) yelled "Chest compressions, chest compressions!" I continued compressions without pause save for brief unavoidable moments involving the rescue devices.

Shortly thereafter the boat deck lowered down the Stokes Litter, which shocked me. It is not configured for recovery, nor does it have installed flotation for over-water rescue. Nevertheless, we transferred the patient in a coordinated effort to the litter and I continued compressions while the crew tightened down the straps. A cervical collar might have been appropriate here, except that the condition of the jaw and skull was such that 1) application might cause further injury, or 2) crush or block the airway, and, furthermore, 3) in support of the neck, the cervical collar must form a bridge between the collarbones

and shoulders and the jaw and skull. It was not a viable option. In lieu of the collar, (b)(6) continued to attend to the position of the head and neck.

After the patient was ready to be hoisted, the boat deck lowered down the Reeves Sleeve and we were told to transfer the patient yet again. We did so, securing the head with the head strap and side stabilizers. As soon as the patient was tied in, I stopped compressions, performed a head-to-toe check of the body straps, cinching them down, and called for the hoist.

It is important to note that no one in the RHIB had training on either rescue device (Stokes or Reeves), nor had the boat deck ever simulated recoveries of this kind. Furthermore, there are no written SAR procedures for RHIB-to-Ship litter hoisting or recovery. Bringing up the RHIB itself wasn't an option given the number of PAX onboard.

The Reeves Sleeve only had a single hoisting attachment, so the patient went up vertically. About halfway up the side the heaving motion caused her head to slip out of the headband and fall. This was absolutely horrifying and had a tremendous effect on the boat crew.

We then departed the ship and waited 1,000 yards off the starboard beam for RHIB recovery.

I wasn't aware until well afterward, when we had returned to the ship, that the patient was ENS Mitchell. She was my DIVO. I have been told by several crewmembers that she later left the ship with a heartbeat but I don't know for sure.

I made several errors, including:

1) Failure to assess the situation and don fins prior to entering the water.
2) Improper application of SAR tactics with additional swimmer.
3) Poor direction of boat crew in pursuance of medical effort, e.g. they could have cut away the coveralls, raised the legs, treated for shock, assisted with CPR, etc.

I strongly recommend the Navy review RHIB-to-Ship procedures and implement appropriate training.

(b)(6)

10JUL18
0900Z

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer; (b)(6) Legal Advisor

Date: 12 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

I have been in the Navy for about 12 years. I have been an IDC for about 6 years. I checked onboard JASON DUNHAM in 30 April 2018.

I have previously encountered deaths in my Navy career, when I was with the Marines.

I was involved in a shipboard drill on 8 July 2018. There was a timeout called for the drill and then medical emergency was called after that. I was down amidships where my (b)(6) was, who is the BoAT deck corpsman. The Captain yelled at me from the bridge that they were doing CPR. When they pulled the RHIB up next to JASON DUNHAM, I notified the pilot house that the helicopter needed to be ready. The helicopter was already being prepared for MEDEVAC. I advised the RHIB team that they needed to keep doing compressions. When I got over to midships, the Stokes litter was already there. The stretcher bearers brought over the Reeves sleeve, and that's what I had them sent down. I only saw two litters available – the Stokes and the Reeves sleeve.

I had (b)(6) prepping some things like advanced airway materials. We continued CPR except for when we were literally moving ENS Mitchell to medical. Her injuries far exceeded what I was able to treat onboard. I did a cricothroidotomy. I thought this was the best way to get access to an airway because of the laceration on the left side of her face. As she arrived at medical we got a baseline set of vitals – she had a weak, palpable pulse. It was extremely hard to tell with chest compressions going on if she had shallow breaths. I did two rescue breaths into the surgical airway and she had bilateral rise and fall. Then we had someone providing rescue breathing via BVM and oxygen. In my opinion, she was alive when she came on board but the disposition was not looking optimistic. If she recovered, I would not have expected her to have any sort of normal life.

I observed that she had an approximately 15 cm cut across the top of her skull, right frontal bone was depressed, forcing her eye shut, her nasal bone was flattened and deviated to the right, and she had a sizeable laceration to the left anterior portion of her mandible. Her bandage had slid off and had to be replaced by a new bandage, which one of my corpsman did. Her heard injuries were consistent with a crushing injury.

We put an Automated External Defibrillator (AED) on her, which analyzes the heartrate and delivers a shock if required. After the patient departed, the Senior Medical Officer (SMO), a Doctor, on IWO said to get IVs in place to push epinephrine. The Medical Officer who supervises me agreed with me that based on her injuries, the disposition was not optimistic (her chances of recovery were low). We were working the whole time while the helicopter was being prepped for flight.

Once the helicopter was ready to go, I sent (b)(6) with my IDC bag along with the (b)(6) (b)(6). I do not know if (b)(6) tried to get IV lines into her.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 2 page(s) typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

13 June

Date

Witnessed by (b)(6)

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer, (b)(6), Legal Advisor

Date: 12 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

On 7 July 2018, it came out in POD for 8 July 2018 that we were going to a small boat operations. To my knowledge this was not briefed at daily ops. I do not recall if I was at this brief.

I had the ~~0300-0600~~ 0330-0700 watch on 8 July 2018, breakfast, then went to deck office where (b)(6) was. Made sure we had enough personnel to conduct both small boat operations and flight operations concurrently. We have done this before. I think that we are adequately manned to support concurrent operations.

Not the most heads up for the boat operations, so I had to scramble to find another boat officer. I like to be on the RHIBs. They are my sailors, so I like being out there. A lot of our JOs are not qualified as Boat Officers, so that was the goal of training on 8 July 2018. Two other people who I approached were unable to be boat officers that morning, so I asked ENS Mitchell to do it. She was recently qualified and she enjoyed small boat operations. We were supposed to have done small boat operations from two days ago and she had volunteered along with a few others. We do ~~not~~ have a watch bill for man overboard scenarios but not for small boat operations. Technically an STT (ship training team) situation, but this was really isolated to the small boat operations. Since I've been 1st Lieutenant and going back to my predecessor, these training teams would not have a watchbill. The defined watchbill covers man overboard. I'm not involved in the assignment of boat officers when it comes to VBSS.

ENS Mitchell and I had similar watches – ~~hers were~~ we had the (b)(6) 0330 to 0700. ~~but obviously in a different location~~ We rotated between the Bridge and Engineer (b)(6)

Loaded Kelly Miller and went away, then lowered and loaded Billy Hampton. I had talked with OPS prior to going on the RHIB. His direction to us was to go do OJT; he did not give us other inputs ahead of time. OPs said that I needed to take midshipmen out there. I wanted to ~~take boat officers only because we needed more but I followed the direction.~~ (b)(6) make JO training the priority, but agreed we need to put midshipmen in the RHIB too.

I divided the people up into different groups – the other RHIB had people for the reenlistment. I chose two boat officers U/I. Max capacity is 18 people at 165 pounds. I did not want to go over 10 people per RHIB to be well under that. For Billy Hampton, they added two more people to the second group of passengers without my knowledge. I gave out the KAPOCs to everyone. No helmets are required for anyone not going via the davit. I made the boat U/Is to take the helmets for practice. I told the passengers to keep three points of contact on the ladder and to follow boat officer instructions. ~~We did not discuss how to ride on the RHIB~~. ATG does not give training about how to sit, but I told people in my RHIB ~~to~~ on how to hold the lines on the RHIB ~~like you would a horse~~. I ~~think it's~~ used common sense/common knowledge to sit on the pontoon, hold it that way, and to know that the more forward you ~~right~~ ride the more dangerous it is. (b)(6) (b)(6) (b)(6) (b)(6)

I discussed how to ~~ride~~ hold on while in the RHIB, but not how to sit in the RHIB (b)(6)

Enclosure (6)
~~Enclosure (62)~~

I communicated with HERO (OOD) via the fixed radio attached to the RHIB. We had an issue getting a second handheld radio, but when we were given a ~~handheld~~ it was not a waterproof one so we went to get a different one, which had a battery issue. We ultimately went out with just the one radio affixed to the RHIB. I gave ENS Mitchell the wearable radio because this was the first time she was alone as a boat officer. She boarded the RHIB via the davit and then just had to monitor PAX transfer via the ladder. She was going to be in the RHIB in the water first, so I wanted her to have the backup radio.

We drive in a direction away from the ship and were passed over twice by the helicopter. ~~Someone on the helo waived at someone in the RHIB.~~ They maintained altitude and were operating safely. We did not have rotar wash or anything like that. The helicopter ~~was waiting for us to be clear so that it could do ops.~~ flew away from us to prepare to land on JTM.

I used bridge to bridge to request permission to deploy ~~victim~~ survivor & SAR swimmer for SAR swimmer training. Hero gave permission but stated that we needed to be 1000 or 2000 yards (I don't remember which) off the starboard bow. We sped up to get to our station. I asked for volunteers to be the survivor. ENS Standard volunteered and I was good with that because I knew that he was qualified second swim class. Therefore, I accepted him as a volunteer. We were going to deploy him on the starboard side with the life preserver on, which has a MOBI. We were having this conversation while transiting to our station. ~~There is not a set procedure to picking a volunteer survivor for SAR practice and~~ (1) whether or not the survivor wears a KAPOC. We heard man overboard, man overboard. My first thought was that they started it already. I later found out that the person ~~to make~~ who made the call was [redacted] and I were talking to each other while we were transitting to the other RHIB. We were talking about how they beat us to the punch and how we didn't get to deploy our SAR swimmer first. I saw [redacted] pulling someone ~~out of the water and blood~~ in the water with blood surrounding them. We realized that it was a real situation and so I yelled to our coxswain to put the vessel in neutral. I told [redacted] to get ready, which he was already doing. That's what you do whenever you deploy a rescue swimmer no matter what. If someone gets ejected from a RHIB, we treat it as a man overboard conducted using a small boat recovery. The coxswain's first job is to maneuver in the vicinity of a person and then to go into neutral so that the propeller does not harm anyone in the water and to safetly deploy our swimmer when a pax falls overboard in a RHIB. There is no training for doing a ~~ship~~ man overboard ~~with a~~ RHIB man overboard. ~~I have tried to connect the dots between the considerations for RHIB operations~~. There is no local training at JASON DUNHAM on what to do in this kind of scenario.

We deployed [redacted], I made sure the water was clear and gave [redacted] one tap, I didn't get to give him all three. (2) He had adrenaline so he went in before that. He was good to go and had his flippers on. I could hear people screaming DIW about the other RHIB. I could see blood in the water. I did not know if it was the KAPOC or actual blob. I told [redacted] to go around the survivors and told him to a safe distance repeatedly to keep them safe. We came up alongside the Billy Hampton. [redacted] brought her into RHIB Billy Hampton. Her injuries were so severe that I knew we ~~could not~~ did not have the time to repair ~~that~~ the RHIB. I had tried to tell [redacted] to come to my RHIB (3) but I do not think he heard me. So I told [redacted] we needed to get her into my RHIB and he nodded.

(2) On the next set of taps. [redacted]

(3) While he was still in the water with Sarah.

(1) We did not discuss who would be the swimmer for the training prior to entering the RHIBs [redacted]

I had four major fears throughout this incident: 1) (b)(6) to come to my RHIB 2) that ENS Mitchell would fall back in, so I told everyone to hold onto the lines and pull them really close together while transferring her to my RHIB. (b)(6) transferred ENS Mitchell to me and (b)(6) and I saw how badly she was hurt, I told (b)(6) to hold her head because I had to do something else, but I did not want to leave until I had a SAR swimmer and any other injured people on my RHIB. Once we had SAR swimmer and the medical kit, we transited back to JASON DUNHAM slow enough to keep her head from being bumped. I started to describe how bad the injuries were to the bridge. I started to say over the VHF that ~~we did~~ I thought we needed a helicopter. Major lacerations to head and arm. I asked (b)(6) for updates. But for 3-4 minutes I was only focused on getting back to JASON DUNHAM. I remember hearing him say that there was a faint pulse. They dumped a thing of plasma on her brain and then ~~wrapping~~ wrapped her head with gauze.

I had put together the medical kit as the SAR officer, so I knew where everything was and I assisted (b)(6) (b)(6) with getting materials. The transit back to JASON DUNHAM seemed very long. We were asked who the victim was and that's when I saw her coveralls and belt buckle and saw that it was ENS Mitchell over the radio. (b)(6) tried to do mouth to mouth using one mask but asked for the second one. (b)(6) couldn't find it, so I helped with that. (b)(6) started doing CPR so I knew that he was solely devoted to chest compressions.

The ship was turning to port and I recommended that the ship stop the turn and turn to STBD so we wouldn't have to cross the wake. This was my 3rd worry. The ship listened and stopped the turn. I requested permission to come along side (starboard midships), and was given permission. I requested a litter. We were given a Stokes litter. I remember seeing (b)(6) and (b)(6) I remember seeing the CO on the bridge wing. I saw XO on the bridge wing. They were there from when we came along side to when we were recovered. I ~~relinquished~~ gave my radio to (b)(6) so that I could give her a distraction ~~and because I needed other things~~. So I screamed for the litter. It was not the right one, but I said, okay, we just need to get her up. We rolled her on her side, then got her in. A lot of a straps and clips were missing, people said that we already had them. (b)(6) sent me an extra. I realized we didn't have enough ties so I asked for another litter. Another one came in about 10 seconds later. (b)(6) So we coordinated getting her out of the one litter, rolled her gently over, slid out old litter and slid in new litter. There was very little body movement. I made sure (b)(6) was good before ~~doing it well~~ ordering it. (b)(6) told us to ~~double check the head~~ continue the chest compressions and make sure her head was strapped in. I double checked each of the ~~clips~~ straps PSL to make sure they were not tied this time and b/c of the inexperience of the crew. Seomone from the ship said to use the steadying line, so I took it off of the Stokes line and put it on. (b)(6) (b)(6)

My fourth worry was her falling out of the litter and back into the water during the recovery to the vessel. For this litter, we raised her vertically. I have not had training on how to raise this kind of litter from a RHIB to the ship. The only part of the ATG inspection includes using the JBAR davit with the SAR litter. We only use that when we deploy the swimmer from the davit itself.

I recommended that Billy Hampton personnel ~~get~~ hc (b)(6) recovered before us because people had actually gone in the water. We had to get about 1000 yards away because of flight ops.

Demeanor was that it was a beautiful day, let's have fun in the RHIBs. I gave my coxswain direction to not cross the bow of JASON DUNHAM. ~~It's a recruitment tool - that's why we put midshipmen on instead of just crew members~~. PSL

off the STBD quarter. (b)(6)

(1) The crew would head back to the ship. (b)(6)

(2) I originally thought it was a midshipmen because I did not recognize her face. (b)(6)

(3) To my knowledge, (b)(6)

(4) Because she seemed very sad/was messed up when she realized it. Enclosure (6) Sarah

(5) and the RHIB had ~~water~~ issues. (b)(6)

① my division's work list for the day.

It was not properly communicated down to deck division that we had small boat operations so when the POD came out that totally changed ~~my plan~~ ①. We were the last to be informed when we are the ones to execute. I was a bit sour about this at first. This required all-hands from my division (every petty officer).

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 4 page(s) typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

0827

Date

Witnessed by (b)(6)

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer; (b)(6) Legal Advisor

Date: 12 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

I checked into JASON DUNHAM in August 2017.

Over the course of the past few weeks, there's been an emphasis on getting the junior officers qualified boat officers. This was a focus area for the new OPSO. My first RHIB ride was about a week to a week and a half before the incident. The previous one was coupled with ATFP drills.

I knew that I would be doing boat officer training on 8 July 2018 after reading the POD on 7 July 2018. On the morning of 8 July 2018, when I got to midships, they were already running through the different groups onto the RHIBs. We were told to clear our pockets, take off our watches, and grab KAPOCs. I ~~get~~ got (b) into RHIB Billy Hampton. There were already four people in it. I went to the starboard side of the RHIB. ENS Mitchell was directing people around although (b)(6) told someone to move (b)(6) ~~to a different position, presumably for balancing the boat~~ from the starboard side to port side to balance the weight. (b)(6)

It was very flat that day, waves maybe 1-2 feet. Went across the JASON DUNHAM's wake, did about four turns (in a S pattern) before people were ejected. I did not think that the previous turns were unsafe at all. The turn that ejected people was a hard turn, but not harder than something I'd seen or felt on a previous RHIB. This time, however, the RHIB popped or slipped over something and then people fell in. It seemed like ENS Mitchell was the last person to go in. There was no announcement that we were starting the turn. It seemed like the boat skipped. The second strike was ~~seconds~~ immediately after ENS Mitchell went overboard. (b)(6) was trying to bring it to neutral but ~~he did~~ could not do that before the second impact. Five in the water were 15-20 yards away from the RHIB. I don't recall having to hold on really hard, with two hands between the legs. I had my feet on the helm, too, so maybe that helped me. I was the only one on the starboard side who did not fall in. (b)(6)

I stood up after the boat stopped and I could see four heads in the water – SAR swimmer, (b)(6) (b)(6) (b)(6) I wondered what hit the propeller. ENS Mitchell was closest to the swimmer. She was laid out face down.

I started to see blood in the water near ENS Mitchell, who was closest to the RHIB. (b)(6) was swimming towards her. I did not know that it was ENS Mitchell until I recounted everyone in the RHIB and saw that she was gone. (b)(6) Kelly Miller left with the casualty and (b)(6)

After realizing it was an injury, I called bridge to bridge and called it away. I felt responsible as soon as they went in the water, so I took over. I stood next to the helm console with (b)(6) At some point, I told (b)(6) to keep (b)(6) calm. We confirmed verbally that she was the only one injured. (b)(6) could not get propulsion to remove the personnel in the water so (b)(6) I called away the propulsion casualty and that we were dead in the water. After recognizing the ~~propulsion~~ casualty, (b)(6) was saying "Oh God, Oh God, what did I do?" Then a midshipman (b)(6) personnel (b)(6) (b)(6) something to the effect of (b)(6) (b)(6) presumably feeling responsible as the casualty. (b)(6)

and the boat engineer helped me get a line ready to throw. The OOD called to Kelly Miller and told the RHIB to come assist. When ~~they~~ [(b)(6)] the SAR Swimmer with ENS Mitchell [(b)(6)] had closed about ½ the distance away from us, I could already see brain matter. I reached over once she got closer and helped pull her on board and stabilize her head/neck as we pulled her into the RHIB.

I observed a cut on her arm, I could see her brain, which was cut, and that her jaw was pretty far removed with a slash across her face. I did not see any breathing. We told [(b)(6)] to come back to the RHIB as [(b)(6)] was deployed by RHIB Kelly Miller with the other three still in the water. The other RHIB came up alongside us and we started the transfer over to RHIB Kelly Miller. Either I or [(b)(6)] [(b)(6)] called away the severity of the head injury.

I picked up the lower part of ENS Mitchell, while [(b)(6)] transferred her holding her at the head and neck. After he got in the other RHIB, I tossed him his medical pack and they took off back to JASON DUNHAM. I briefly thought about getting ~~packs~~ personnel out of their RHIB to give them more space, but didn't do that because we still had people to recover and were DIW.

I worked with the SAR swimmer and other crew members to haul the three survivors into the RHIB.

I was on the radio while the SAR swimmer unfouled the propeller. I am not aware of any casualty to the RHIB that would have contributed to the initial impact. Once we restarted and were limping back to JASON DUNHAM, that's when the electrical shock was brought to my attention, so we put a line around [(b)(6)]

Ahead of the incident, the demeanor of the RHIB was excitement.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of __ page(s) typed by [(b)(6)] I have had the opportunity to make any changes and to correct and initial all errors and changes.

[(b)(6)]

13 JULY 2018

Date

Witnessed by [(b)(6)]

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer, (b)(6) Legal Advisor

Date: 12 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

I will have 18 years on the 19th of this month. I have fourteen years of platform experience. I got trained to be a coxswain and qualified in 2003. I never went to coxswain school, but rather trained under experienced boatswains.

I was in the watch section that had midnight to 0700 watch on 8 July 2018, so we saw the POD and knew we would have small boat operations that day. We found out that we were going to use two boats (Boat officer training for one, VBSS for the other). I got about two hours of sleep between watch and coming down to the boat deck.

(b)(6) is the division LPO. We only have four coxswains on board ((b)(6) (b)(6) (b)(6) and myself). The other BMs have not gone to school for this. Have not had manning-related issues thus far, sometimes it is tough to man everything, but we've always been able to make it work.

When first getting into the RHIB on 8 July 2018, I set the trim all the way down before turning the engine on for the first time. With the first passed 1000 yards off of port beam, did reenlistment then asked for permission to practice SAR swimmer. We were given permission but told to come in to 500 yards off. We had a midshipman volunteer to be the survivor for the SAR swimmer to recover. I am responsible to assist with the recovery, so I stay on the helm throughout the process. The recovery was done in accordance with procedures (correct side of RHIB, back to RHIB for recover).

We went back to JASON DUNHAM, went from having just 5 to 7 midshipmen passengers. The sea state was maybe ½ foot to 1 foot swells. Even going straight, the boat did not rise. Visibility was clear. Current was slight. I did not need helm orders to stay alongside DUNHAM for onload/offload. It was breezy but light, maybe 5 kts. Water temperature was high 80 degrees. We did not discuss survivability.

We came around the stern of the DUNHAM then went to the portside to a point about 400 yards away. My intention was to do a high speed circle. The RHIBs are designed to maneuver at high speed. There was no concern about demonstrating donuts and pivot turns (both diagrammed for info only, we did not execute a pivot turn on 8 July) to the passengers given the sea state.

I planned on doing a donut with a diameter of 50 yards with full throttle. I made it too about 90 and 180 degrees of the turn when the boat had an impact that jarred everyone to starboard. I have never experienced anything like this before in my 15 years of driving. I was almost thrown off of the helm. My hand was thrown free from the throttle. The impact of the jolt was similar to when going full throttle in a heavy sea state and the RHIB goes airborne then flat-bottoms. I felt the jolt through the entire boat – from my feet, the console. I heard the same hit that you hear when gear goes up in the air and comes back

down after flat bottoming. The water was not shallow – I think it was 500-1,000 feet deep. There was nothing around, no shadows, no marine life, the water was clear and undisturbed (no visible wake). Optimal conditions for boat operations.

As I was recovering myself, I pulled myself up using the helm, and I started to turn to port to straighten out and stop the turn. After regaining myself, my first thought was that I needed to stop the propeller. As I was starting to do that, we hit ENS Mitchell.

It takes a few rotations to get the rudder full. I wanted to go amidships. The momentum that we had was what took us about 100 yards away from the personnel. When we got the screams of medical emergency, that's when I tried to apply throttle, but we had lost propulsion. Every time I applied throttle, I heard a knocking and the helm shook. I think that this is because of the KAPOC fouling the screw.

I did not observe (b)(6) go in the water, I saw the three personnel go in as they were in my line of sight as I was falling myself.

I have never had training on what to do when someone enters the water unintentionally. No training on man overboard on RHIB. This did not concern me beforehand. The personnel that I've received training from as a coxswain had not experienced this either. This includes when performing donu.s and pivot turns.

If the boat has more than 14 people in it, the boat slows down, sits lower, and the engine sounds audibly different, like it's bogged down. I heard the engine make that sound here, too, when I started the turn. This was not unusual when making a sudden turn at full throttle. This is different than the sustained noise of a laboring motor with lots of people in it.

I took the trim of the outdrive all the way up, that's when I saw the KAPOC all the way up. When I trimmed up, the trim was still all the way down like it had been when I first set it. When I trimmed up and tried to reach the KAPOC, I got shocked three times before turning everything off (including batteries). (b)(6) and I lifted the aft compartment to see if there was anything causing that. There was a little bit of bilge, but the batteries were fine – no leaking. Trim had been fully functional. The boat had been fully functional all day.

WATER IN THE

I assisted with bringing ENS Mitchell onboard the RHIB, transferring her to the Kelly Miller along with the class A medical kit so they could get her back to JASON DUNHAM. We then recovered the other three personnel ((b)(6) (b)(6) (b)(6)) along with the SAR swimmer.

(b)(6) cleared the propeller, putting the KAPOC on the boat. Once I helped him back on board, I restarted the vessel. I dropped the trim back down. I did not see any damage on the skeg and the propeller. I thought that the foam from the KAPOC in the water was flesh and that shook me up, but then I saw that it was from the KAPOC.

Returned to the JASON DUNHAM, disembarked personnel.

As coxswain, my job is the safe operation of the boat, safety of the personnel. When people are in the water, my job is to keep the outboard away from people in the water. If the sea state requires it, I

maneuver the vessel to keep the stern away from them. Everyone has a job on the small boat team, we don't cross roles. SAR does his role and I do mine, for example.

When doing a donut, I give an audible direction for people to hold on. I think that I did this on the morning of the 8th, too. I do not initiate the turn as aggressively as I can, I ease into it. I observed that everyone was holding on before I started it.

Everyone was pretty excited that morning. Everyone likes getting in the RHIB. They like to play around and break the monotony of being onboard. I thought we were going to do some training, show the midshipmen a good time. The only guidance that we were given was that we were going to be conducting boat officer training, there was no plan to conduct X, Y, and Z. We concentrated SAR procedures with the first trip and the fun of the maneuverability.

I had coxswained with ENS Mitchell previously in Rudy Inlet in Norfolk/Virginia Beach. There were probably 6-8 ft swells in October and she had no issues hanging on. I had total confidence in her ability.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of __ page(s) typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

13JUL15

Date

(b)(6)

Witnessed by

DEPARTMENT OF THE NAVY

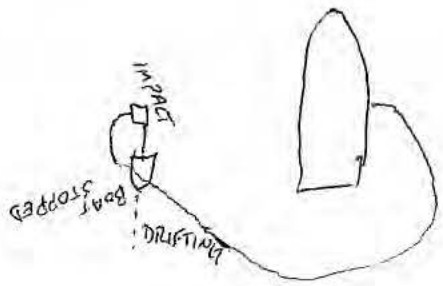
VOLUNTARY STATEMENT

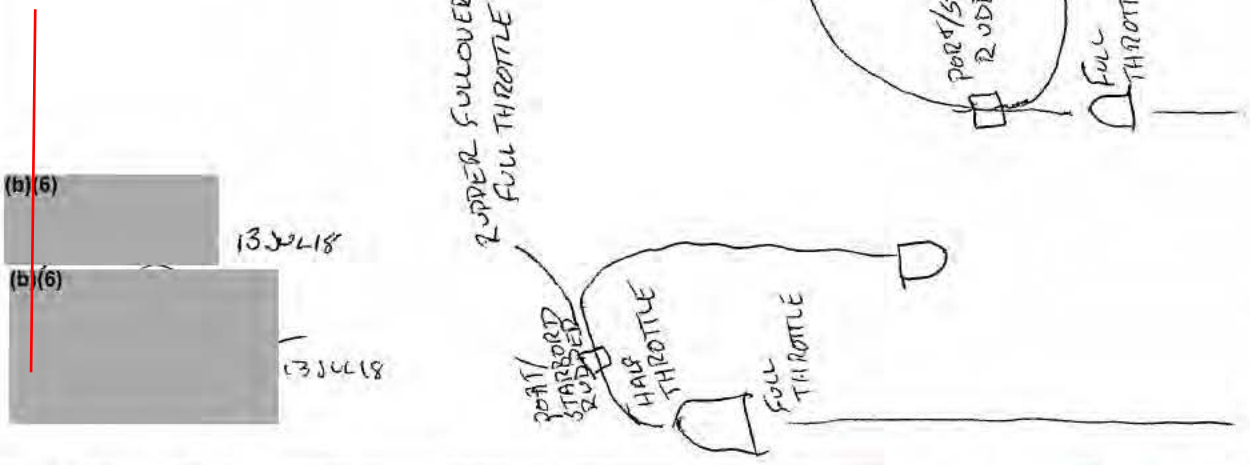
1. PLACE: JASON DUNHAM (PDG 103)

2. DATE: 12 JULY 2018

I, (b)(6), make the following free and voluntary statement to (b)(6), (b)(6), whom I know to be the investigating officer and legal advisor.

I make this statement of my own free will and without any threats or promises extended to me. I fully understand that this statement is given concerning my knowledge of





(b)(6) 13 JUL 18

(b)(6) 13 JUL 18

Interviewee: [redacted]

Interviewers: [redacted] Investigating Officer; [redacted] Legal Advisor

Date: 12 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

I have been in the Navy for 1.5 years and this is my first assignment. I am in the process of qualifying as a boat engineer.

On 7 July 2018, I'd been told that I was going to be U/I the next time we did small boat operations. I reported to the boat deck on 8 July 2018. [redacted] instructed us to wear a KAPOC, tuck pant legs into boots, and wear a helmet. I boarded the RHIB Billy Hampton. Our first trip out was primarily to do the reenlistment. ENS Mitchell was in charge.

After we changed out our passengers, we went away from the ship and then made a tight turn. [redacted] might have said something right ahead of the turn. I think we made a hard turn to port. I think that I was braced the wrong way for the direction of the wake that we hit. I saw a large wave right before we were ejected it was 2.5 ft and bigger than anything else out there that day because the seas were otherwise calm. That's why I think that it was THE 13JUL18 wake. I was facing away from the RHIB when I fell out. There was an [redacted] and [redacted] in the water with me. We swam towards each other. We saw the blood in the water and swam ~~away from it.~~ TOWARDS THE RHIB BILLY HAMPTON. 13JUL18

The other RHIB SAR swimmer recovered ENS Mitchell and then also recovered us while [redacted] was performing CPR on ENS Mitchell and the RHIB Kelly Miller went back to the JASON DUNHAM.

I did not hear or observe anything that made me think the boat was not functioning normally prior to the incident.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of __ page(s) typed by [redacted] I have had the opportunity to make any changes and to correct and initial all errors and changes.

[redacted]

13JUL18

Date

Witnessed by: [redacted]

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer, (b)(6) Legal Advisor

Date: 12 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

I was the boat engineer for the RHIB Billy Hampton on 8 July 2018 because it was also the date of my reenlistment. I enjoy being out on the small boats.

I have been in the Navy for 5 years, I have been on JASON DUNHAM for about a year and I have been boat engineer for about half a year.

We went out on the RHIB on 8 July 2018 in the morning. I did my reenlistment, then we did the SAR recovery drill. We dropped off three midshipmen, my DIVO, and MCC. We picked up 4 midshipmen and a new ensign. Shortly after we picked them up, we went to conduct more boat officer training. ENS Mitchell was the boat officer still and I was still the boat engineer. The boat crew did not change, just the passengers.

(b)(6) tried to do a hard left and then everyone lost their balance. Boatswains like to show off a little bit and do these tight maneuvers. Boatswains like to go quickly and go fast. I did not hear him yell out a warning or anything. I leaned forward as the starboard side went up.

As we were starting the turn, it was really calm there were no waves. It felt like we hit a wave. We were about 120 degrees through the turn before we felt the impact. We saw basically everyone on the starboard side go overboard. They had been holding on. ENS Mitchell had just finished telling people to hold between their legs. The hard turn was routine ops.

After we were 180 degrees through the turn, the RHIB was dead in the water (DIW). I went aft to look at the propeller and saw three people in the water (b)(6) (b)(6) and (b)(6)) and I saw (b)(6) swimming back with ENS Mitchell. The water around (b)(6) was getting darker, that's when I realized there was an injury. When I got to the prop, I could see that there was a KAPOC stuck in the screw. The RHIB Kelly Miller crew also told us about the KAPOC in the propeller when they came over. (b)(6) said bring the boat towards us, we told him it was ~~not there~~ (DIW), so he said "throw something then". The two midshipmen ~~through~~ THREW it out. (b)(6) didn't catch it, so they pulled it back and did it again. (b)(6) and (b)(6) pulled her onboard.

I tried to distract the midshipmen from looking at ENS Mitchell, I knew it would upset them to keep looking. After ENS Mitchell was transferred off of Billy Hampton, I talked to (b)(6) about cutting the KAPOC off of the propeller. I then tried to keep (b)(6) calm. He freaked out right after the incident, he was hyperventilating, shaking, tears in his eyes. (b)(6) started to get more emotional after RHIB Kelly Miller returned to JASON DUNHAM.

When we first got in the RHIB, the trim was down. The sound of the engine while operating was normal and such that I think the engine was trimmed all the way down.

Demeanor in the morning before the incident was that it was a good day for small boat operations.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 2 page(s) typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

13JUL18

Date

Witnessed by: (b)(6)

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer; (b)(6) Legal Advisor

Date: 12 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

I checked into JASON DUNHAM on 22 June 2018. I am assigned to the weapons department and now CA.

On 7 July 2018, I knew that I was going to be on the RHIBs because of the POD, my need for the qualification, and an email from my department head. On 8 July 2018, we were standing around the boat deck for 20-30 minutes while (b)(6) was putting people into groups. OPS gave (b)(6) (b)(6) and I a quick brief on how to be in a RHIB. THE INSTRUCTION INCLUDED LINE HANDLING, AND SAR HAND SIGNALS. THIS IS NOT AN ALL INCLUSIVE LIST. (b)(6)
ENS Mitchell was the boat officer of the RHIB Billy Hampton. When it pulled up to off-load personnel, I got on. After I was on, two extra midshipmen joined us because the boat crew said there was extra room. The boat crew distributed us so that the weight was even. We got direction from both the SAR swimmer and (b)(6)

We went away from JASON DUNHAM. It was fun. It was a beautiful day and the water was relatively calm. You had to hold on. After the fourth or fifth turn everyone on the starboard side fell out. I only saw myself and the two people beside me fall out. We were in the middle of the Red Sea, so I was not sure how far we had transited. (b)(6) did not announce this particular turn.

I don't remember what happened right before I fell. I did not see (b)(6) fall or someone from the port side fall into the middle of the RHIB. It took me a ~~minute~~ moment to swim up to the surface. I saw someone floating face down. I didn't know that it was ENS Mitchell at the time. I remember seeing (b)(6) and the midshipman. I don't know if the SAR fell out separately or if he decided to jump out after us.

(b)(6) swam over and asked if the three were okay, I remember starting to freak out and just saying blood and waiving my arm as the universal symbol for help over here. (b)(6) told us to stay together. We tried to swim together back to the RHIB, but we kept having to turn and look where we were going and then flipping onto our backs to swim. My boot fell off at one point. We had some confusion on which boat to swim to and someone told us the Billy Hampton. I saw ENS Mitchell being lifted into the boat on one of the times when I turned around. (b)(6) came and helped us get to the boat and then into it.

I don't remember what happened right before we were ejected. I did not see anything in the water that I can recall. I don't remember having to hold on extra and then falling out, so maybe we fell out at the beginning of a turn.

I think the small boat ops were done after someone said "Why aren't we doing small boats?" It was recently organized. It was fun before the incident. They did make it a priority to get the midshipmen on the boats. (b)(6) was standing on the boat deck waiting with me to get onboard and she needed that qualification. It was frustrating that they got on first.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 2 page(s) typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

13 JUL 19

Date

(b)(6)

Witnessed by:

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer; (b)(6) Legal Advisor

Date: 11 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

On 8 July 2018, we did small boat operations for the second time during my midshipman summer cruise. I participated in small boat operations the week before, which was a lot of fun. All of the midshipmen could not participate previously because one of the ribs broke before we could all ride in it.

On the morning of the 8th, all midshipmen were mustered midships on the JASON DUNHAM boat deck. I was in the third set of crew members to go into the RHIB (hereinafter Billy Hampton). (b)(6) (b)(6) had initially divided us into groups. The (b)(6) was overseeing this evolution. I had been waiting around for about 45 minutes before getting into the Billy Hampton. I got into the Billy Hampton (rib) from the JASON DUNHAM. I was joined by a group of three other midshipmen and three members of ship's company. We were taught the previous week about how to climb down to the ribs. We had life jackets on. ENS Mitchell was wearing a helmet in addition to her life jacket. This why I thought she was the boat captain. ENS Mitchell and (b)(6) were already in the rib when I got in. ENS Mitchell was sitting in the front starboard side of the rib. I was in the middle of the port side. I have drawn a picture of the seating arrangements on the ship along with the relationship between JASON DUNHAM and Billy Hampton at the time when ~~ENS Mitchell went overboard.~~ we boarded the Billy Hampton (b)(6)

When we were getting going, ENS Mitchell told us to hold onto the section of rope between our legs. There were calm seas that morning. Much calmer than during the previous week. When we pulled away from JASON DUNHAM, the Billy Hampton ruend to the right and went around the DUNHAM. After about 3 to 5 minutes, my side of the rib started to dip in the water before the boat righted itself and then the other side started to dip in the water a bit. We made a sudden turn. (b)(6) fell into the center of Billy Hampton. Some people laughed at that. (b)(6) also wobbled a bit during the turn. Someone said that the battery died. I saw three bobbing life jackets. I saw the SAR swimmer and (b)(6) in the water. I saw someone floating facedown. I could see a khaki belt. I thought we needed to do something because someone was unconscious and needed help. The SAR swimmer had either fallen in with the others or jumped in shortly thereafter. There was a huge pool of blood in the water around ENS Mitchell. The only thing that we could do was waive to the ship, so that's what we did.

The Billy Hampton was dead in the water. I heard someone call that on the radio. The other RHIB, Kelly Miller, came over to assist. I looked back and saw a SAR swimmer with ENS Mitchell. I saw the lacerations to her face and her skull injury. (b)(6) was in shock. (b)(6) tried to help hold onto the Kelly Miller RHIB while ENS Mitchell was transferred into it so that she could be transferred back to JASON DUNHAM.

(b)(6) and (b)(6) were recovered from the water. ENS Mitchell's KAPOC was stuck in the propeller. I also saw blocks of foam floating around. After the KAPOC was cut free, the RHIB could be operated again. But, we all had to sit in the front of the RHIB because there was a current running in the water near where people would sit if they were in the back of the boat.

(b)(6) (coxswain of Billy Hampton) drove the RHIB back to JASON DUNHAM. (b)(6) took over as boat officer. We waited on the RHIB for about 20 minutes while the helicopter was set up and the Kelly Miller was recovered. We disembarked following the disembarking procedures.

During the previous week's small boat operation, (b)(6) was the coxswain and (b)(6) was the boat officer. There were rougher waves that day. We did about 30 minutes of maneuver. I do not recall being told how to hold on to the RHIB or how to sit on the pontoon. The purpose of the small boat operation that week was to get other JASON DUNHAM personnel qualified. I also heard "this [small boat ops] is what we do to convince you to go SWO." It was a lot of fun, which is why we asked to go a second time. There were two or three separate trips (boat ops with different passengers). I did not feel that they were trying to shake us off or that they were trying to splash us.

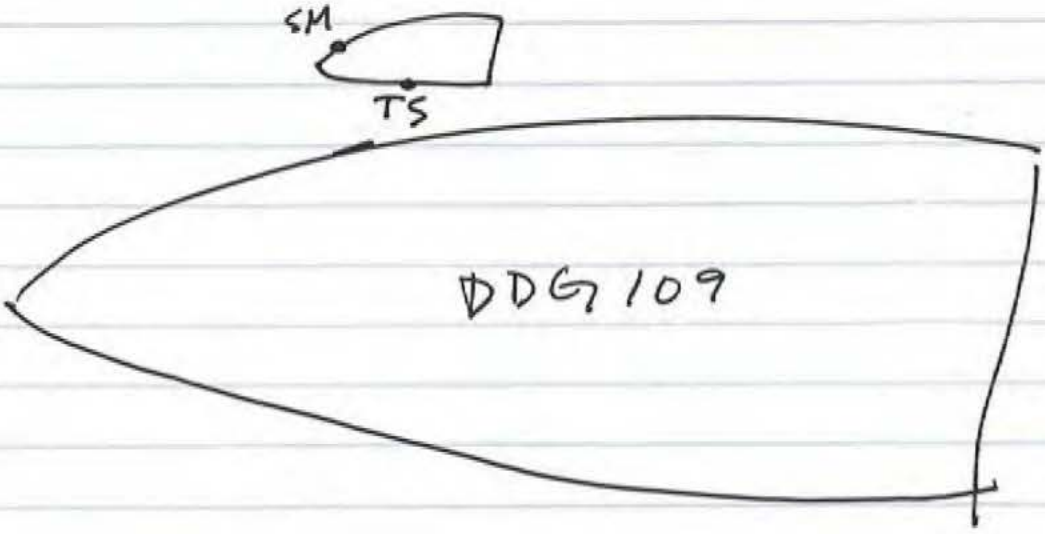
The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 2 pages typed by (b)(6) and my accompanying drawing. I have had the opportunity to make any changes and to correct and initial all errors and changes.

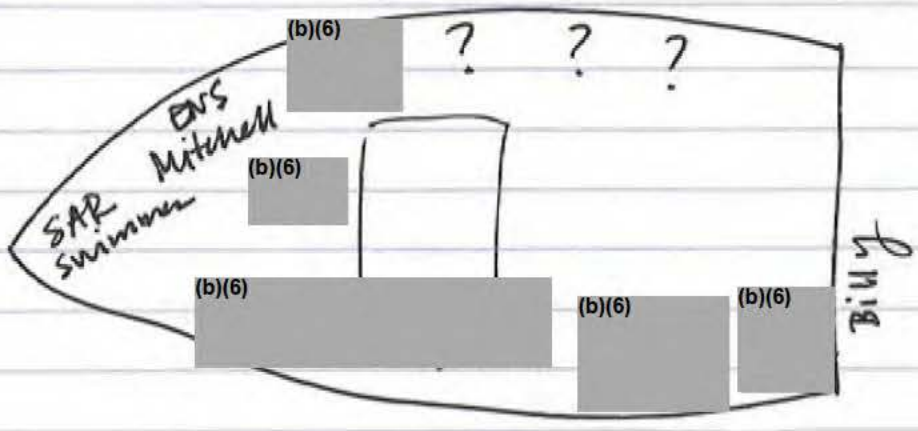
(b)(6)

12 JULY 2018

Date

Witnessed by: (b)(6)


SM
TS
DDG 109


(b)(6)
? ? ?
EWS
Mitchell
(b)(6)
SAP
swimmer
(b)(6)
(b)(6)
(b)(6)
Bill

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer, (b)(6) Legal Advisor

Date: 11 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

On 8 July 2018, in order to prepare for small boat operations, the midshipmen gathered amidships JASON DUNHAM and were given life jackets. I stopped working out to go participate in this evolution. We had been briefed on KAPOCs during the previous small-boat option. After getting into the rib, I think that I sat on the starboard side of the vessel. The water was much calmer than it was the previous time that we (Midshipmen) participated in small boat operations this summer. It was fun at first. I do not know if we hit a wave or what happened. I thought that I was the only person who fell out, but then I saw (b)(6) and ENS Mitchell, who was floating upside down. I could not recognize her at first because her uniform was soaked. I went to flip her by her leg and saw all of the blood. I started to react. Another sailor ultimately flipped her over. The Billy Hampton did not come towards us to recover us, but it looked like they were trying to, I later learned that it's motor could not be started. (b)(6) ultimately pulled us away from ENS Mitchell while the other SAR swimmer recovered her. I think that he did that so that we would not see her injuries. I think that I was the closest to ENS Mitchell in the water and while onboard Billy Hampton.

We started out having a lot of fun. People were smiling. We were not out long enough to really start doing anything. (b)(6) was the coxswain. Nothing seemed out of the ordinary that morning.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of one page typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

7/12/18

Date

Witnessed by: (b)(6)

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer; (b)(6) Legal Advisor

Date: 11 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

On 8 July 2018, I participated in small boat operations from the JASON DUNHAM. I initially was not going to go in Billy Hampton when ENS Mitchell and the other crew members were in the RHIB, but a (b)(6) who had broken us into groups, said that the remaining midshipmen should just go with the last group. Once on Billy Hampton, I moved to sit next to (b)(6) We took off after we were told to hold on to the rope on the RHIB with our hands between our legs. It was kind of an abrupt departure after that. We went faster than we had the previous week. The sea state was calmer.

After we made a sharp turn, the starboard side fell off. I saw a person floating upside down. All that I could see was a belt. I saw blood and no life vest. I said "Man Down!" The RHIB's engine was not working. I think they were trying to get it started to maneuver the RHIB closer to the crew who were in the water. (b)(6) (b)(6), and I threw lines to the overboard sailors. I think that I was told to pass the line to them. The SAR swimmer, (b)(6) and (b)(6) swam to the RHIB.

The demeanor on the 8th was excitement at least for the midshipmen. I was ready to have fun and along for the ride. This was training for the crew. One of the earlier crews on RHIBs had put a midshipman overboard without a life vest on so that he could be recovered. In fact, when ~~I first went~~ I first observed People (b)(6) overboard I wondered if maybe the plan was to get people in the water to practice recovering them.

In general, I think everyone handled this incident to the best of their ability.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 1 pages typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

12/14/18

Date

Witnessed by: (b)(6)

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer; (b)(6) Legal Advisor

Date: 11 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

On 8 July 2018, we did small boat operations for the second time during my midshipman summer cruise on JASON DUNHAM. After we saw the plan of the day and that it included small boat operations, we asked if we could go again.

On the morning of the 8th, all midshipmen mustered midships around 0900 on the JASON DUNHAM for small boat operations. Those who had not done it the week before were in the first group to get a ride in the RHIBs. Each group had 2 or 3 midshipmen in it. I was briefed on the KAPOC during the previous week's small boat operation and was not re-briefed on it during the morning of 8 July. We generally went in smaller groups this time as most groups had three midshipmen during the previous week. Our group of 4 in the RHIB Billy Hampton was the exception. (b)(6)

Once we left the side of JASON DUNHAM and started ~~doing donuts~~ moving while changed direction, once, quickly, I fell forward from my seat on the portside of the RHIB towards the center, bumping my head. After I was helped up, I saw that there were people in the water. There were five individuals in the water – 3 in KAPOCs, one SAR swimmer, and ENS Mitchell.

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 1 pages typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

12 JUL 2018

Date

Witnessed by (b)(6)

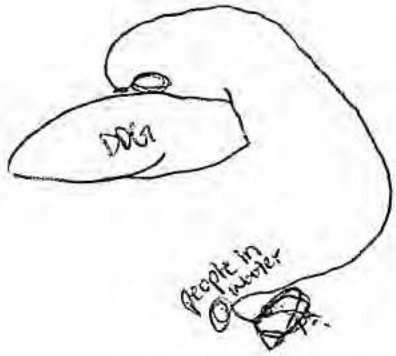
DEPARTMENT OF THE NAVY
VOLUNTARY STATEMENT

1. PLACE DDG 109
2. DATE 1958 on 11 JULY 2018

I, (b)(6) , make the following free and voluntary statement to (b)(6) and (b)(6) ,

whom I know to be the investigating officer and legal advisor.

I make this statement of my own free will and without any threats or promises extended to me. I fully understand that this statement is given concerning my knowledge of



Statement provided on a seperate sheet.

NO FURTHER ENTRY

(b)(6)

11 JUL 2018

Witnessed by

(b)(6)

Interviewee: (b)(6)

Interviewers: (b)(6) Investigating Officer; (b)(6) Legal Advisor

Date: 12 July 2018

Location: USS JASON DUNHAM (DDG 109)

Subj: Summary of Voluntary Statement

I make the following statement freely and voluntarily:

I have been in the Navy for 4.5 years. I have been a rescue swimmer for 4.5 years. My medical training is up to level A, which means competency with a level A medical kit. Level A medical kits include a tourniquets.

My involvement with ENS Mitchell's trauma began after we did a routine surveillance flight around JASON DUNHAM on 8 July 2018. I saw three people in the water. I thought they were midshipmen. I saw a life vest behind the RHIB that was dead in the water. As we were on final approach, we were told that it was a medical emergency and that we needed to prepare to evacuate her. I started tearing apart the helicopter to make room for her. The helicopter was still being downloaded of weapons and prepared for flight, when I finished my preparation and went to medical. Both the medical and aircrews moved expeditiously and I do not think there were any unnecessary delays. The helo was prepared amazingly quickly. I saw (b)(6) (b)(6) (b)(6) I saw that she had a tracheotomy and an AED placed. I assisted with carrying her out to the helicopter. I assisted with (b)(6) in doing CPR once she was transferred out of medical, we traded off duties. The AED tells you "good compressions, push harder, wait, etc." and has a reading. (b)(6) was trying to place an IV, which was hard to do. We noticed that blood had soaked through the head bandage, so we cut that off and replaced it. We were 30-40 minutes away from the hospital when we got a message from the AED that shock was advised, which gave her a faint pulse that was not there for very long. We continued CPR until we got to the emergency room, where she was rolled into the nearest trauma room and the staff hooked her up to machines to read her pulse. They pronounced her dead at 1245. I was there with (b)(6)

My training to be a SAR swimmer was 2.5 years total with about 2 months of SAR-specific training, half was medical and half was swimming. In talking with SAR swimmers from ships, they use the same medical kit as I do. When we deploy, we wear a CO2 facilitated life vest (not a KAPOC).

The above statement is true and accurate to the best of my knowledge and belief. The above statement consists of 1 page(s) typed by (b)(6) I have had the opportunity to make any changes and to correct and initial all errors and changes.

(b)(6)

13 JUL 18

Date

Witnessed b (b)(6)

LT JACK USN

DEPARTMENT OF THE NAVY
COMMANDER, DESTROYER SQUADRON TWO EIGHT
9727 AVIONICS LOOP SUITE 200
NORFOLK, VA 23511-3730

5800
Ser N00/116
18 Jul 18

FIRST ENDORSEMENT on (b)(6) ltr of 17 Jul 18

From: Commander, Destroyer Squadron TWO EIGHT
To: Commander, Carrier Strike Fighter Group EIGHT

Subj: COMMAND INVESTIGATION INTO THE DEATH OF ENS SARAH JOY MITCHELL, USN

1. Readdressed and forwarded.

2. I have reviewed subject investigation and concur that ENS Mitchell was "in the line of duty" and her death was "not due to her own misconduct".

3. I concur with the findings of fact, opinions, and recommendations.

4. My point of contact in this matter is (b)(6) he can be reached by telephone at (b)(6) or by e-mail at (b)(6)

K. M. KENNEDY

Copy to:
(b)(6)

DEPARTMENT OF THE NAVY
COMMANDER CARRIER STRIKE GROUP EIGHT
UNIT 200297 BOX 1
FPO AE 09502

5830
Ser N02/121
18 JUL 2018

From: Commander, Carrier Strike Group EIGHT
To: Commander, Navy Personnel Command (PERS-13)

Subj: LINE OF DUTY DETERMINATION IN THE CASE OF ENS SARAH JOY MITCHELL, USN

Ref: (a) JAGINST 5800.7F (JAGMAN)

Encl: (1) (b)(6) ltr of 17 Jul 18

1. I reviewed enclosure (1) pursuant to reference (a) and determined further investigation and endorsement are not necessary. The findings, opinions, and recommendations of the investigating officer, as endorsed by Commander, Destroyer Squadron TWO EIGHT, are approved. ENS Mitchell's tragic and untimely death occurred while she was in the line of duty and not due to her own misconduct.

2. By copy of this letter, Commanding Officer, USS JASON DUNHAM (DDG 109), is directed to make required service and medical record entries.

3. A full copy of the investigation will be maintained by this command for two years from the date of this action. The point of contact for this matter is (b)(6) (b)(6) Carrier Strike Group EIGHT, (b)(6) (b)(6)

E. H. BLACK III

Copy to:
NAVY JAG (CODE 15)
COMUSFLTFORCOM
COMFIFTHFLT
COMNAVSAFECENT
COMNAVSURFLANT
COMDESRON TWO EIGHT
USS JASON DUNHAM

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Enclosure (63)

DEPARTMENT OF THE NAVY
COMMANDER DESTROYER SQUADRON TWO EIGHT
9727 AVIONICS LOOP SUITE 103
NORFOLK, VA 23511

5830
Ser N00/109
15 Aug 18

FIRST ENDORSEMENT on (b)(6) ltr of 27 Jul 18

From: Commander, Destroyer Squadron TWO EIGHT
To: Commander, U.S. Fleet Forces Command
Via: (1) Commander, Carrier Strike Group EIGHT
(2) Commander, Naval Surface Forces Atlantic
(3) Commander, U.S. Fifth Fleet

Subj: COMMAND INVESTIGATION INTO THE DEATH OF ENS SARAH JOY MITCHELL, USN, AT SEA, ON 8 JULY 2018

Ref: (l) Article 1033, U.S. Navy Regulations of 1990
(m) Article 4.22.6, OPNAVINST 3120.32D

Encl: (61) Surface Warfare Officer School Basic Division Officer Course Small Boat Operations Instructional Presentation

1. I have reviewed subject investigation, and I approve the findings, opinions, and recommendations, subject to the following:

a. Opinions 2b, 10–13—Modified. I disapprove of the characterization of complacency with respect to small boat operations and failure to apply PBED (what the investigating officer refers to as "Root Cause 2") as a root cause of the ejection of personnel from RHIB BILLY HAMPTON. Instead, I characterize them as a contributing factor. Given the inadequacy of Fleet wide guidance on RHIB operations and of the PQS standard (reference (f)) fueling disparate understandings of proper small boat operations aboard JASON DUNHAM, I find it unlikely a brief would have identified the maneuvering, occupant seating, and centerline lifeline issues which directly impacted the outcome. While I firmly believe in the value of the PBED process and believe it would have been an opportunity to focus the crew of RHIB BILLY HAMPTON on the inexperience of many of the persons aboard and on safety in general, I do not believe such a brief would have changed the outcome. [FF 1–40, 46–62, 75–98, 116, 160, 164, 190, 241–251, 257–301, 309–311]

b. Opinion 19a—Added. Root Cause 1 and Root Cause 3 combined to create the error chain resulting in the mishap. While (b)(6) executed a high speed "donut" turn, gaps in guidance and in the PQS suggest he was not presently aware of the concept of "tripping" and he did not knowingly and intentionally accept unmitigated risk in doing so. The physics of tripping is included in Boat Coxswain PQS (reference (g)) Fundamentals (102), which is a pre-requisite

for Bow Hook (301). Bow Hook is a prerequisite for Coxswain (302). The time between qualifying as Bow Hook and Coxswain can be significant, so Recommendation 3 of the investigating officer's report is critical. The danger of this type of high speed turn is taught at Center for Surface Combat Systems (CSCS) Coxswain School (COI K-062-0625) but is not a pre-requisite for Boat Coxswain qualification. (b)(6) did not attend this school. [FF 28, 31, 38, 40, 46–62, 75–98, 257–301]

c. Opinion 19b—Added. The actions of the boat officer and of the boat's senior officer inadequately guided the coxswain in execution of the training evolution. The boat officer, sitting forward on the sponson, was not in a position to provide immediate direction to the coxswain and the boat's senior officer was not qualified as boat officer. However, references (l)–(m) and enclosure (61), Surface Warfare Officer's School (SWOS) Small Boat Operations Instructional Presentation at Basic Division Officer (BDOC) Course, indicate the boat officer has overall responsibility for the safety and welfare of the crew and passengers and the boat's senior officer has overall authority of the boat. This is not clear in the NAVEDTRA PQS, reference (f). The boat officer did not review coxswain training plan prior to or during the training evolution, and the boat's senior officer did not provide direction until after the accident. [FF 23–36, 46–62, 75–98, 241–51]

d. Opinion 22—Disapproved. I disapprove Opinion 22. JASON DUNHAM's schedule the day of the incident was what I would expect for a multi-mission platform at the peak of its readiness on deployment. JASON DUNHAM was no more tasked on the day in question than it was on any day of its Composite Training Unit Exercise. Being highly tasked is the norm, but "task saturation" is a mischaracterization of this situation. It is essential to recognize a point of task saturation does exist and leaders must be able to identify this point and be able to call a stop when it is reached, speaking hard truth to higher. JASON DUNHAM had not reached this point. However, given the number of personnel from the early morning watch required to conduct helicopter and RHIB operations, supervisors should have given consideration to timing of these evolutions relative to the watch requirements placed on the individuals to be involved so as to maintain the required circadian rhythm for all watchstanders. I consider this a lapse in the planning process already identified in the opinions relating to PBED. As previously stated, I do not believe this tragedy would have been avoided with better planning alone. [FF 1–45, 105]

e. Opinion 23—No Evaluation Stated. I recuse myself from evaluation of Opinion 23 regarding JASON DUNHAM Command Master Chief's participation in the Chief Petty Officer selection board. I declined to request a waiver of her participation in the selection board based on her having volunteered to participate, the importance of this particular selection board, and the presence aboard JASON DUNHAM of an operationally experienced Operations Specialist Master Chief (three surface combatant sea tours including two on DDGs) who is fully capable of providing expert senior enlisted counsel to the Commanding and Executive Officers and the entire crew.

f. Recommendation 1—Modified. I recommend appropriate administrative action in the case of the Coxswain of RHIB BILLY HAMPTON, (b)(6) I do not believe disciplinary action is appropriate due to the lack of clear, consistent, timely, and complete Fleet-

wide training for coxswains, the responsibility of the boat officer and the boat's senior officer, and the failure in forcible backup by (b)(6) JASON DUNHAM's most senior and experienced coxswain.

f. Recommendation 3a—Added. I recommend a review of reference (f) include consideration of additional prerequisites to qualification as Coxswain and Boat Officer to ensure currency in essential fundamentals, such as a test bank of questions for required examinations and establishment of Coxswain School (COI K-062-0625) as a prerequisite for qualification, with any waivers to be approved by TYCOM. I also recommend inclusion of training on the roles and responsibilities of the boat officer and the boat's senior officer, similar to that contained in enclosure (61).

g. Recommendation 3b—Added. I recommend Afloat Training Group, in coordination with CSCS, review small boat operations training requirements for MOB-S certification and consider adding training on fundamentals to include the rigging of centerline lifeline and passenger operational risk management.

h. Recommendation 3c—Added. I recommend SWOS review its curriculum for inclusion of additional topics of instruction to ensure all reference (f) small boat fundamentals are covered, to include use of centerline lifeline and proper passenger distribution during transit.

i. Recommendation 3d—Added. I recommend TYCOM develop and order use of a formal checklist to be briefed to passengers prior to every small boat movement. As a model, consider the formal safety brief—covering general safety, entrance, positioning within helicopter, what to do in the case of an emergency, and egress—delivered by aircrewman prior to any helicopter flight.

j. Recommendation 3e—Added. As many of the findings of this report relating to safe small boat operations were not previously well-known, I recommend TYCOM develop a lesson topic guide and training materials which address these findings, to include those fundamentals taught as part of CSCS Coxswain course but inadequately understood in the fleet. Upon approval of training materials, I recommend a safety stand down be directed for all personnel involved in RHIB operations. I also recommend inclusion in the safety stand down of a review of unit level boat officer training programs to ensure required rigor and formality.

2. Actions

a. I will take appropriate administrative action as recommended by the investigating officer, and report completion to the final reviewing authority through the chain of command on or before 5 October 2018.

b. I will direct Commanding Officer JASON DUNHAM's to review the ship's watch bill to ensure application of circadian rhythm requirements while enabling conduct of required operations on a multi-mission destroyer. I will also direct him to assess the quality and application of the ship's PBED process. I will report completion to the final reviewing authority through the chain of command on or before 20 October 2018.

K. M. KENNEDY

Seamanship

Small Boat Operations

References

- Boats and Small Craft, NSTM 583
- Boat Officer's Handbook
- Flags, Pennants and Customs, NTP 13 (B)
- SORM
- NAVEDTRA 14343 Boatswain's Mate
- Boat Information Book (BIB)
- Navy Search and Rescue (SAR) Manual, NTTP 3-50.1

Terminal Objectives

- Given a small boat scenario, DESCRIBE the parts of the craft and safety precautions prescribed in the NSTM 583 (Small Boats and Crafts).
- Given a small boat scenario, DISCUSS the proper procedures of a small boat to include: lowering/hoisting, start up/shut down, and underway maneuvering as discussed in the NSTM 583, SORM, and the Boat Officer's Handbook.
- Given a scenario, DISCUSS small boat etiquette in accordance with the Boat Officer Handbook.
- Given a search and rescue (SAR) situation, DESCRIBE the duties and procedures of a rescue boat in accordance with the SAR Manual.

Enabling Objectives

- DISCUSS the components of the small boat structure; to include the hull, rudder, outdrives, handrails, hoisting sling, and sampson post.
- DISCUSS the components of the small boat engineering systems; to include the equipment and procedures for the starting, fuel, drainage, and outdrive systems.
- DISCUSS the marine reduction gear, jet drive, and outboard motor.
- DISCUSS the instrument panel.
- DESCRIBE the indications and warnings to determine if a system is malfunctioning.
- EXPLAIN the safety precautions that must be observed during the operation of a small boat.

Enabling Objectives

- STATE the basic duties and responsibilities of each member of the small boat crew: coxswain, boat engineer, bow hook, and boat officer.
- DISCUSS the hoisting and lowering capabilities of U.S. Naval vessels.
- DISCUSS the procedures and precautions for launching and recovering small boats during calm and heavy weather.
- DESCRIBE the equipage found on a small boat.
- DISCUSS planinng speed, pivot turns, and how to prevent tripping and causing a small boat to become airborne.
- DISCUSS rendering or receiving honors for officials embarked on a small boat and between larger naval vessels.

Enabling Objectives

- DISCUSS the different boat hails made during day and night and the proper procedure for embarking or disembarking personnel.
- DISCUSS the flag staff insignia for embarked officers.
- DISCUSS the actions taken if conducting small boat operations during colors or other ceremonies.
- LIST the equipment required for rescue boat operations.
- DISCUSS the duties and responsibilties of each member of the rescue boat crew.
- DISCUSS the search and rescue (SAR) swimmer's hand, flare, and light signals.

Enabling Objectives

- DISCUSS the procedures to be followed when approaching and recovering a survivor in the water.

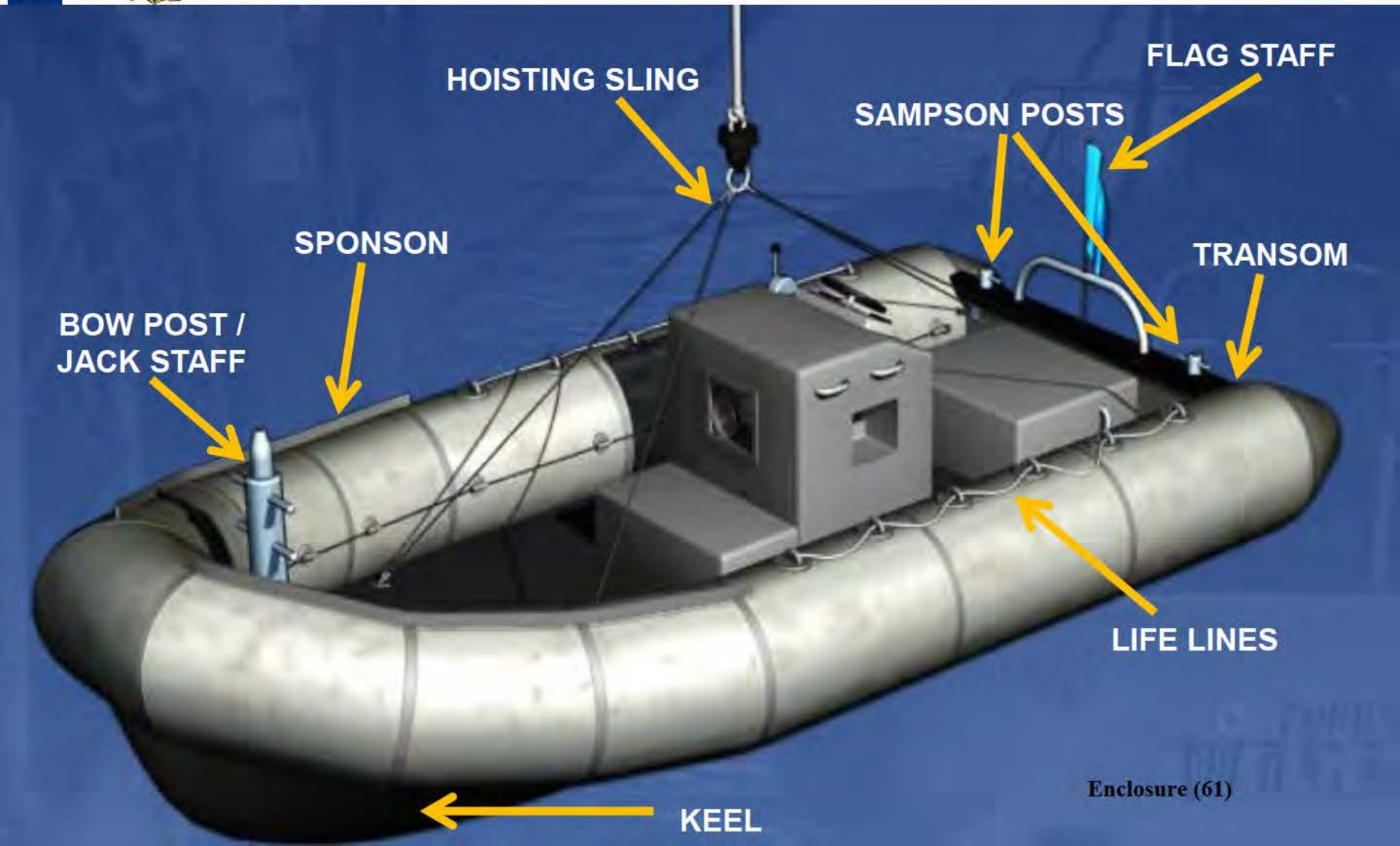
Types of Small Boats

- 7m / 11m Rigid Hull Inflatable Boat (RHIB)
- Captain's Gig / Admiral's Barge
- 11m Landing Craft Personnel (Light) (LCPL)
- Paint Punt

Enclosure (61)

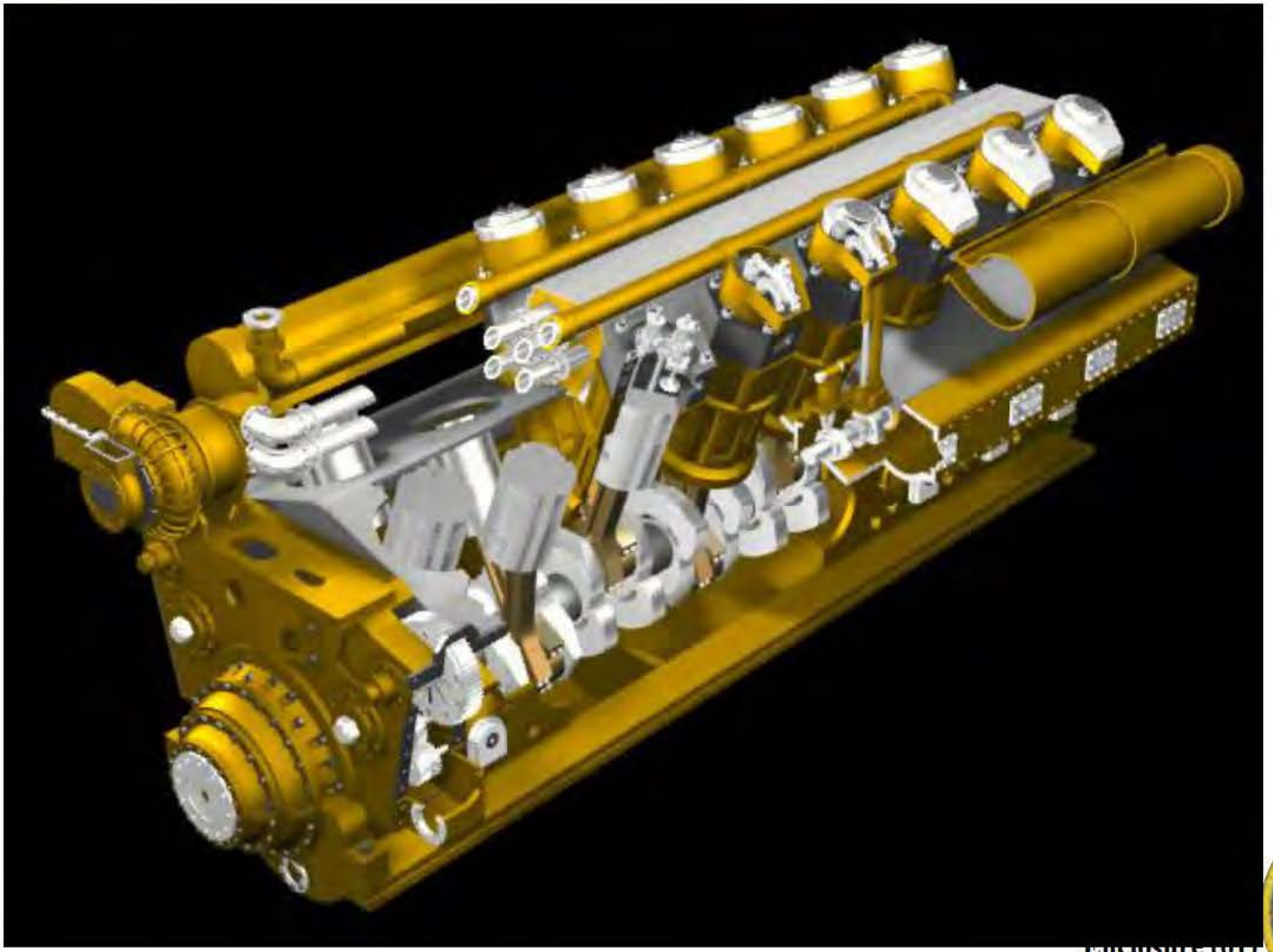
Enclosure (61)

RHIB Features



Enclosure (61)

Small Boat Engineering

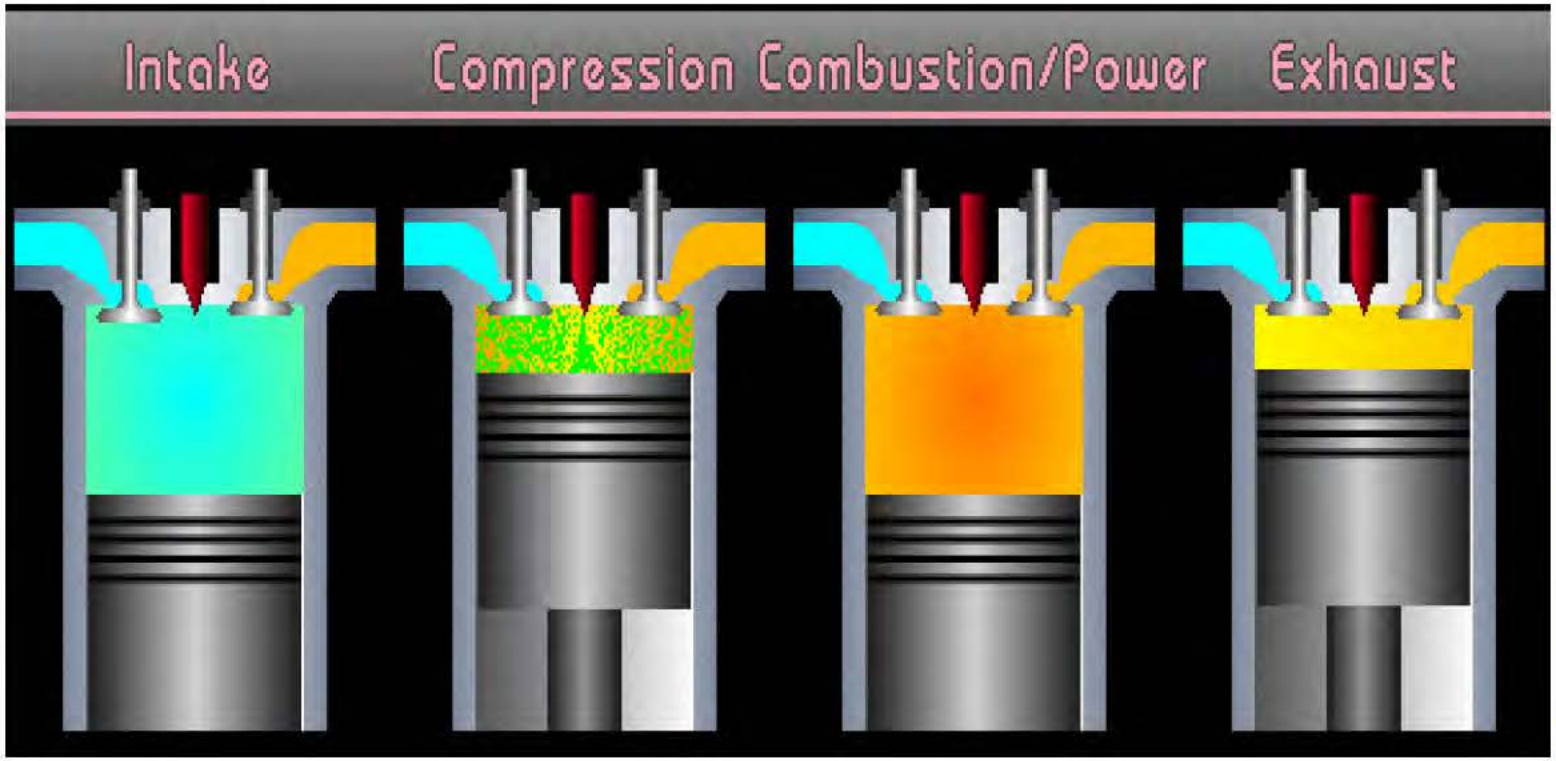


Small Boat Engineering: Maintenance

- The **service life** and maintenance requirements of any diesel engine are greatly influenced by the **speed and load factors** imposed by the user
- An engine operating at the fully rated power output, will require **more maintenance and overhaul** than the engine would normally require if the power output was reduced to about 80 percent and the speed reduced to about 90 percent

Small Boat Engineering: Starting

- Small boat engines start easily when the throttle (fuel injector rack) is slowly opened, by the operator, to the full position during cranking



Small Boat Engineering: Cooling System

- Engine Coolant:
  - Small boat engine coolant transfers heat from the hot areas of an engine through a heat exchanger
  - Without engine coolant, the small boat engine components would rapidly overheat and fail due to the large amounts of heat produced by engine combustion
- Water:
  - In some small boats, water is used as coolant because it is readily available and because of its large heat capacity (the quantity of heat it can absorb)
  - Depending on its source, water quality can vary
    - For example, seawater contains large amounts of dissolved salts, as well as seaweed and debris

Small Boat Engineering: Lube Oil System

- Combustion Engine Lubricants:
  - Lubricants contain additives that keep combustion products like soot, wear, and oxidation products, in suspension
  - Lubricants reduce the amount of contaminants deposited on engine parts, which is particularly important in modern, high speed, turbocharged diesel engines
- Lubricants are used to:
  - Reduce friction
  - Dissipate heat
  - Prevent corrosion

Small Boat Engineering: Lube Oil System

- Friction Reduction:
  - Friction is decreased by using the correct lubricant for the specific application
  - Lubricants form a film between contacting surfaces, thereby separating the surfaces and reducing friction
  - Consequently, the wear and seizing of parts is also reduced
- Heat Dissipation:
  - Friction, generated by heat, must be rapidly dissipated to prevent damage to small boat engineering equipment

Small Boat Engineering: Lube Oil System

- Corrosion Prevention:
  - Corrosion resulting from continuous exposure to a marine environment (salt) is a major maintenance problem
  - A lubricant should accomplish the following:
    - Remain on the surface of the engineering equipment to protected it under adverse conditions
    - Prevent, or significantly reduce, the formation of corrosion, in the presence of moisture or seawater

Small Boat Engineering: Fuel Oil System

- The 7m and 11m Rigid Hull Inflatable Boats (RHIBs) use F-44 (JP-5) for fuel
- Fuel Contamination:
  - During the transfer and handling of F-44, the danger of contamination with foreign material, known as Foreign Object Debris (FOD), increases. FOD can cause the motor to stall or not start
  - The major contaminants are:
    - Water
    - Rust
    - Sediment
    - Oil Soluble Soap

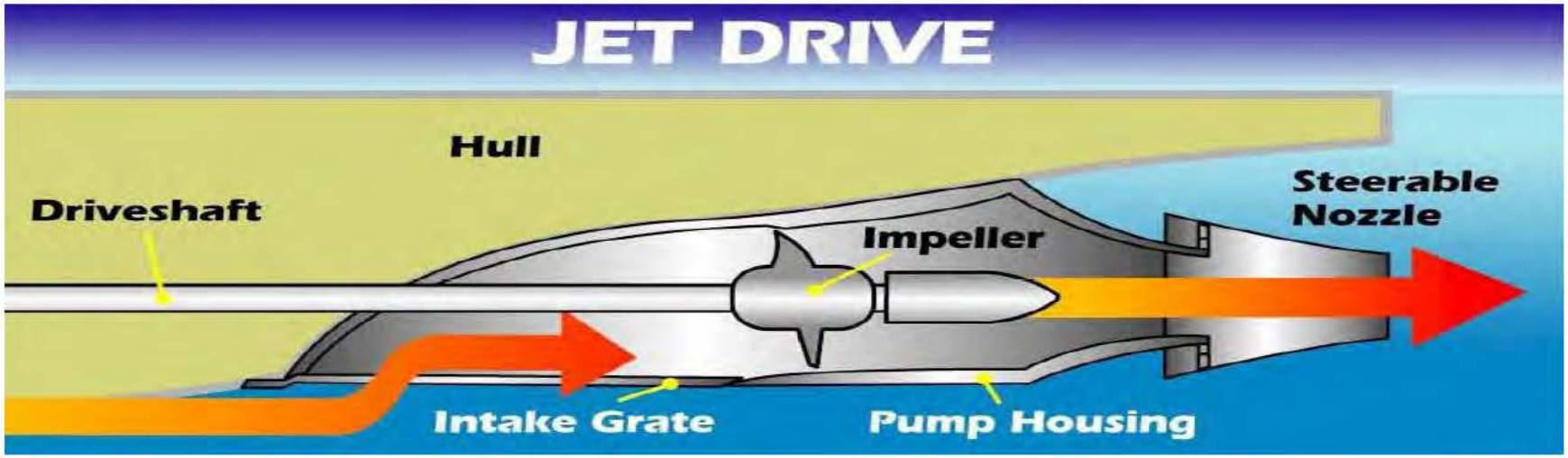
Small Boat Engineering: The Valve

- Before using mechanical equipment, a valve alignment must be performed in accordance with start-up procedures
- Only one valve must be aligned on the 7m/11m RHIB
- The valve is referred to as the Sea Cock Valve
  - The valve allows sea water suction for the cooling of the engine
  - If not opened prior to starting the small boat, the diesel engine will start, but burn itself out

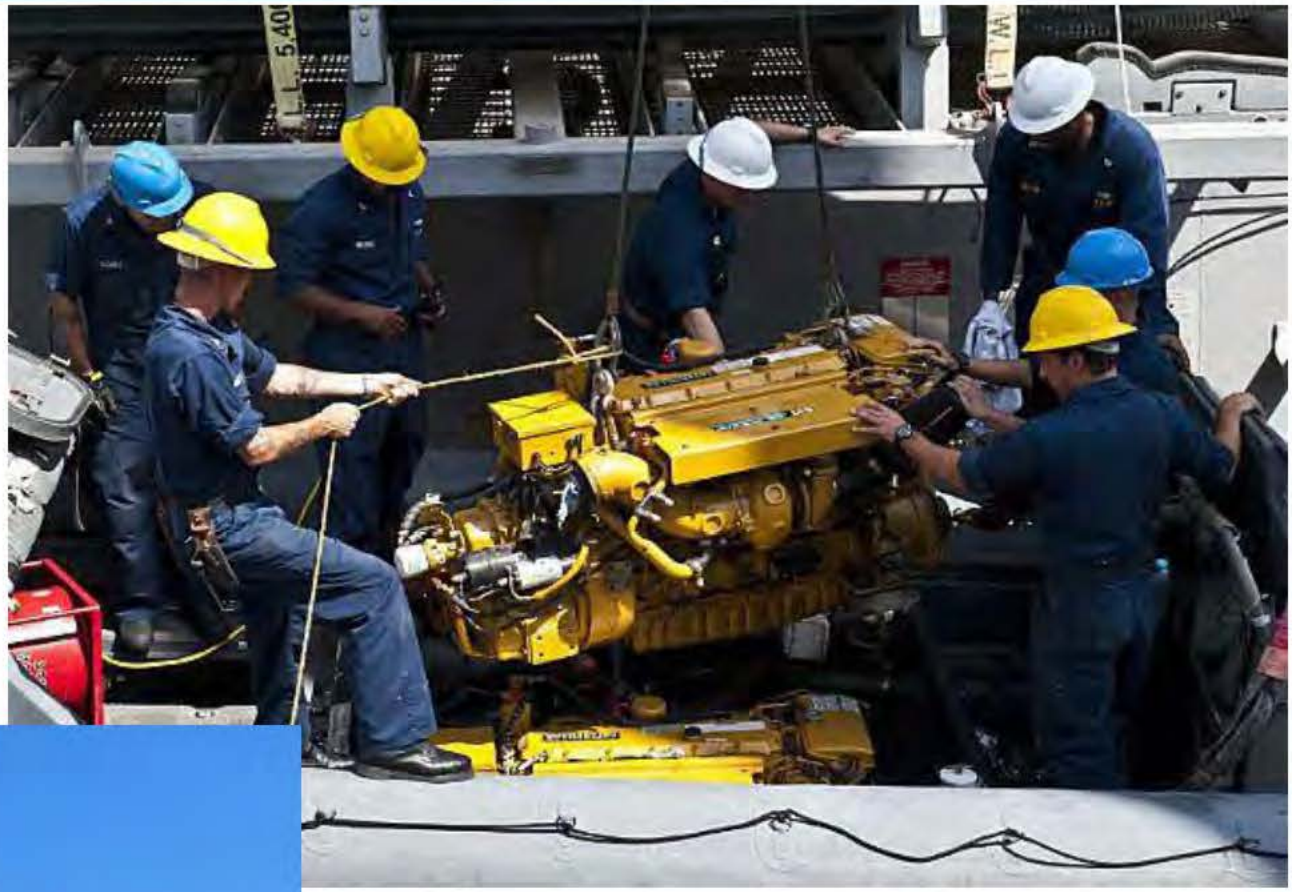
Small Boat Engineering: Engine Problems

- Immediately report any of the following engineering issues or casualties with the small boat:
  - Difficulty starting the engine
  - Abnormal engine oil temperature
  - Abnormal engine oil pressure
  - Abnormal engine tachometer reading
  - Unusual engine noise
  - Unusual engine vibration
  - Excessive smoke

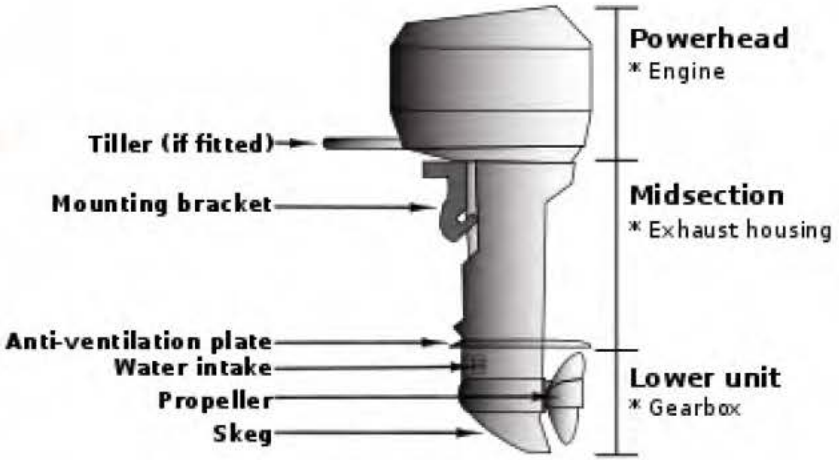
Small Boat Motors: Jet Drive



Small Boat Motors: Inboard Motors



Small Boat Motors: Outboard Motors



Small Boat Safety Precautions

- Crew:
  - The crew must make sure that fire extinguishers are in place and charged
  - Inherently buoyant lifejackets must be readily accessible and enough should be available for all members of the crew and passengers
  - The Navigation Rules must be strictly obeyed
  - If a boat swamps or capsizes, do not panic and stay with the boat
- Passengers:
  - Passengers must obey coxswain commands and embark in a quiet, orderly manner and move as far forward in the boat as possible
  - Once embarked, stay in place, and keep all parts of your body in the boat

Small Boat Crew

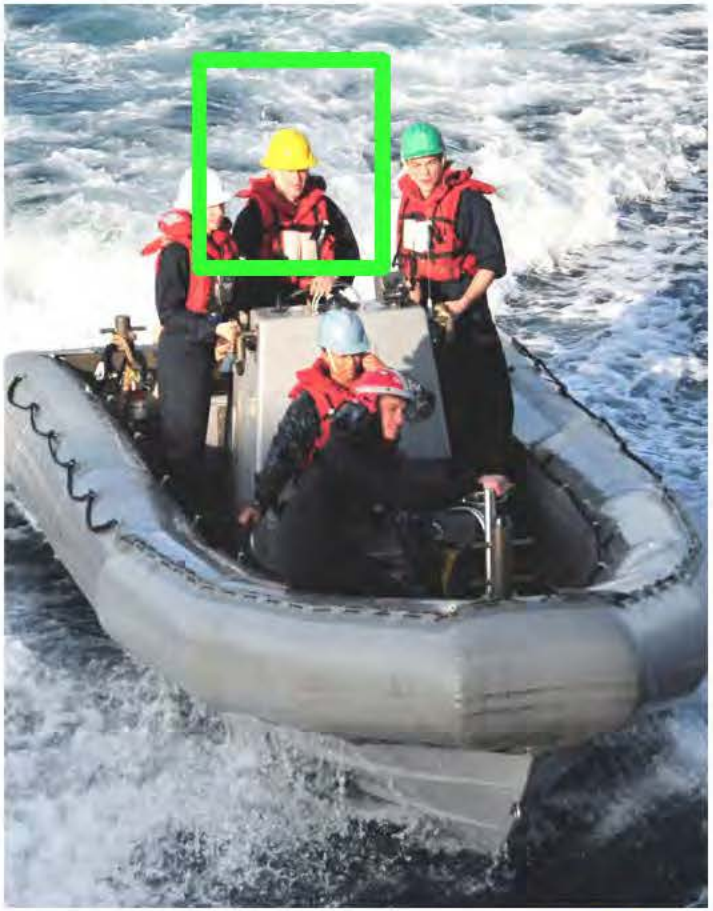
- The Boat Crew consists of at least three personnel, but the Commanding Officer can add as required.
  - Coxswain
  - Bowhook
  - Boat Engineer
- All crew members must be at least Second Class swimmer qualified

Small Boat Capacity

- 7M RHIB:
  - Full Load Condition:
    - 2970lbs: full fuel hold, hoisting slings, and payload capacity (total weight of 16 persons (including the crew) at 185 lbs each)
- Boat Registry Plate:
  - The Boat Registry Plate displays the overall length, boat type, U.S. Navy hull registry number, builder, commissioning information (city, month, year), contract number, crew capacity, and overall passenger capacity
  - Small boat capacity is rated for normal weather conditions
  - When operating with a mission payload (VBSS, MIO, etc) the Boat Officer must take the weight of extra equipment into account

Small Boat Crew: Coxswain

- The Coxswain is responsible for the safety and welfare of all passengers and the boat and is in charge of the boat when a Boat Officer is absent
- The Coxswain is familiar with all aspects of the boat including the operation, safety gear, navigation, and shiphandling maneuverability in fair and foul weather

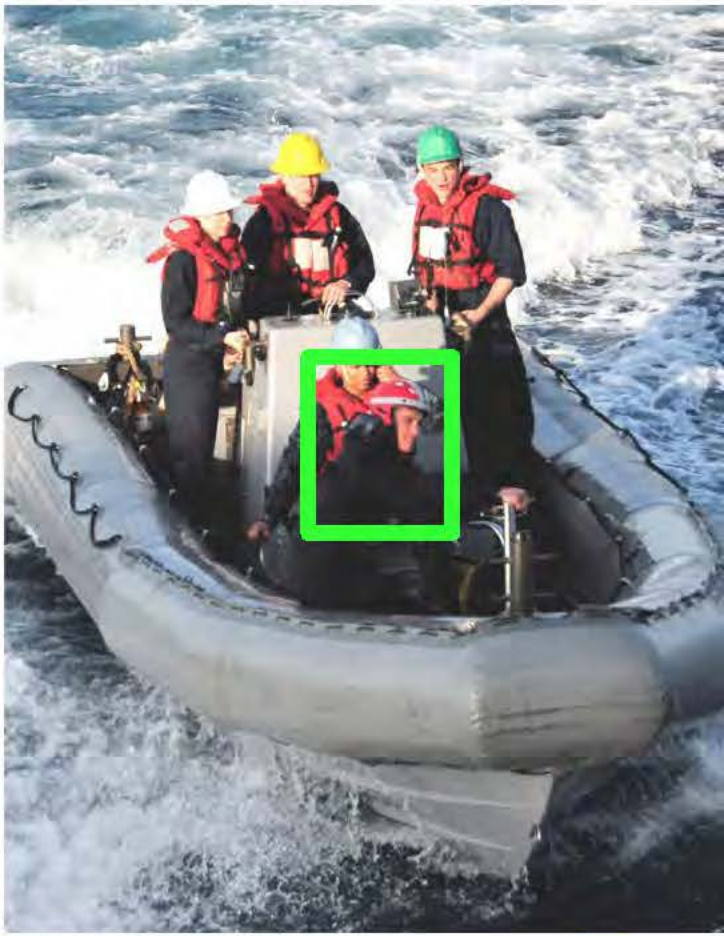


Small Boat Crew: Engineer

- The Engineer ensures proper operation and maintenance of the boat's engines, makes repairs or adjustments while underway, and is responsible for completing the daily Boat Report
- The Engineer must also ensure that the repair parts are onboard, the boat is fueled, and the battery is charged
- He or she doubles as the Sternhook, and handles lines and fenders when mooring or getting underway

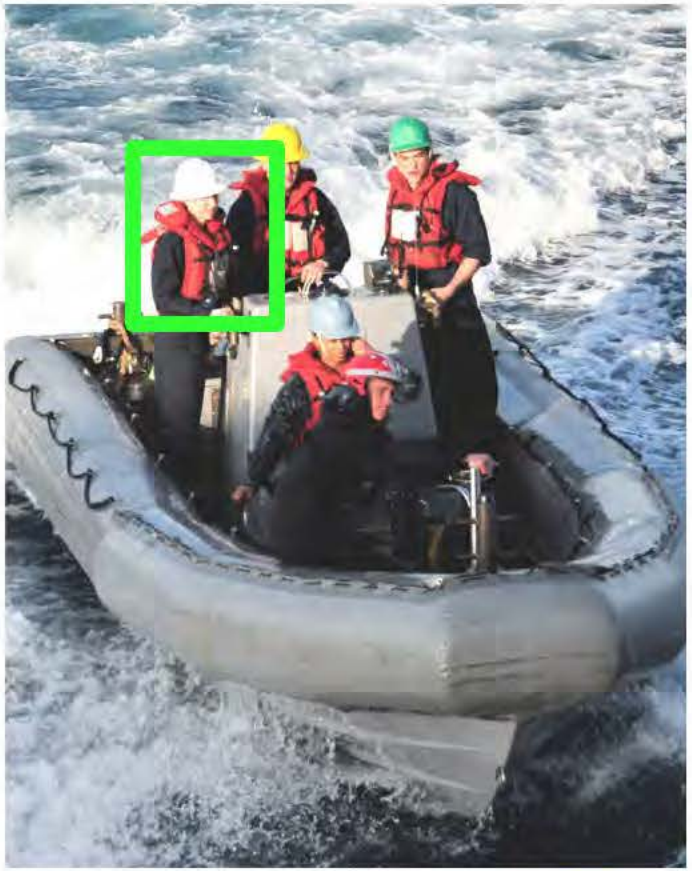
Small Boat Crew: Bowhook

- The Bowhook assists the Coxswain in the operation of the boat, provides a lookout while underway, and assists in the handling of lines and fenders
- The Bowhook has the knowledge to operate the boat in an emergency or when the Coxswain must be relieved
- The Search and Rescue (SAR) swimmer usually doubles as the Bowhook



Small Boat Crew: Boat Officer

- The Boat Officer directs the Coxswain to ensure safety precautions are followed and the boat is navigated correctly and is overall responsible for the safety and welfare of the crew and passengers
- The Boat Officer identifies the senior line officer aboard and notifies them that as the senior officer, they have overall authority of the boat
- He or she will ensure that the Engineer inspects and fuels the boat before launch



Small Boat Crew: Boat Officer

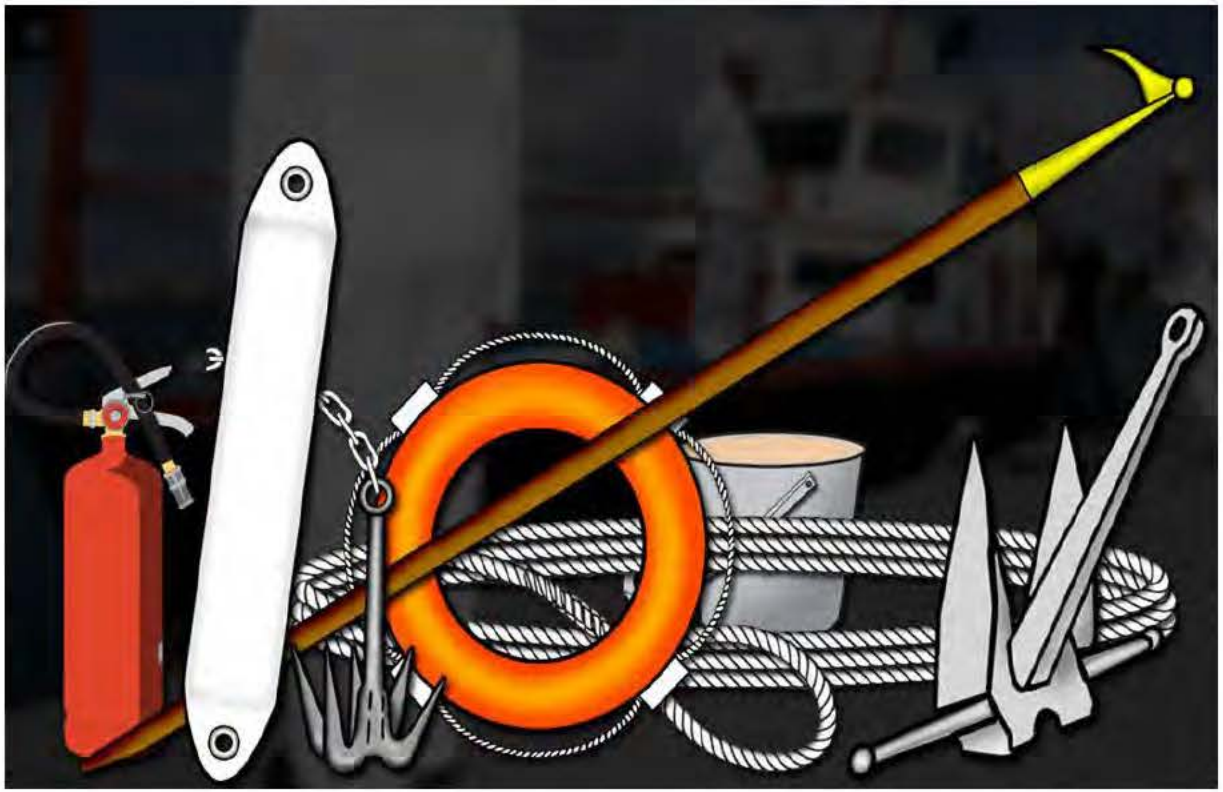
- A vessel must use a Boat Officer when the following conditions exist:
  1) When entering foul weather or reduced visibility (existing or expected) and on long trips
  2) The first boat trip in a foreign or unfamiliar harbor and when required by local regulations
  3) When returning large liberty parties after sunset
  4) Whenever the Commanding Officer requires

Additional Small Boat Crew Options

- Corpsman: Administers first aid to the boat crew or a recovered person
- Gunner's Mate: Usually armed as the Shark Watch
- Coast Guard Legal Detachment (LEDET): A LEDET is a specialized maritime law enforcement team
- Visit, Board, Search and Seizure (VBSS)

Small Boat Equipage

- Bow hook
- Stockless anchor
- Fenders
- Life Ring
- Sea Painter
- Steadying lines
- Grapnel hook
- Compass
- Fire Extinguisher
- Handheld BTB radio
- Lifejackets for passengers



Hoisting and Lowering Terminology

- Fall: A heavy cable used to lower or hoist the boat
- Monkey Lines: Knotted safety lines that hang from the top of the small boat davit to the water's edge.
  - Crew members aboard the small boat are required to support 80% of their weight with monkey lines as the boat is lowered or hoisted
- Sea Painter: The line attached to the bow of the boat and connected to a forward section of the ship
  - The Sea Painter line allows the boat to "ride" along with the ship to provide the boat crew with the necessary time to fasten or unfasten lines in the water

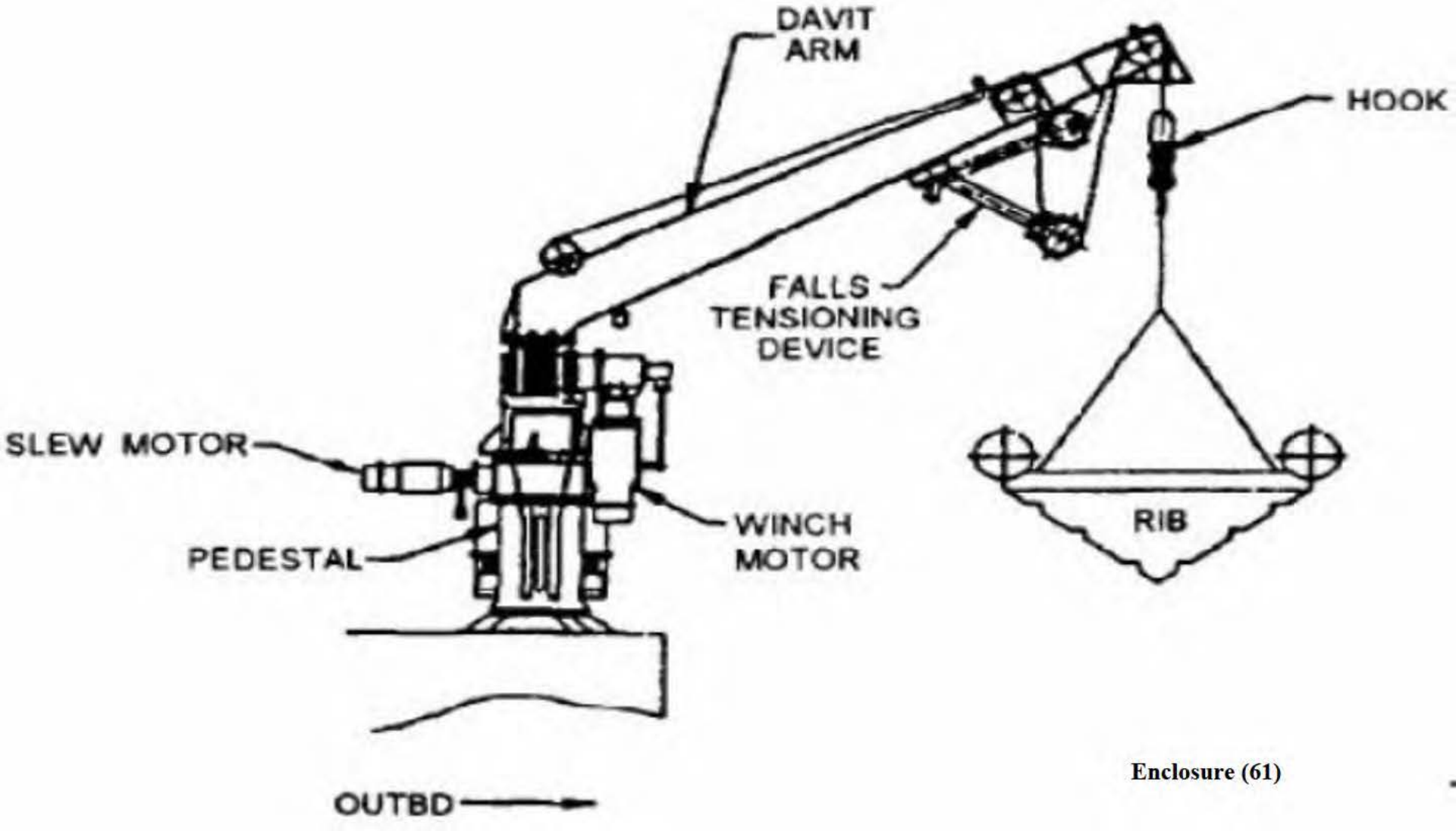
Hoisting and Lowering Terminology

- Steadying Lines: The lines that are tended by the boat deck crew to keep the boat from twisting
- Lizard Line: The line that is spliced into the sea painter, which is used to deploy and retrieve the sea painter

Hoisting and Lowering of Small Boats

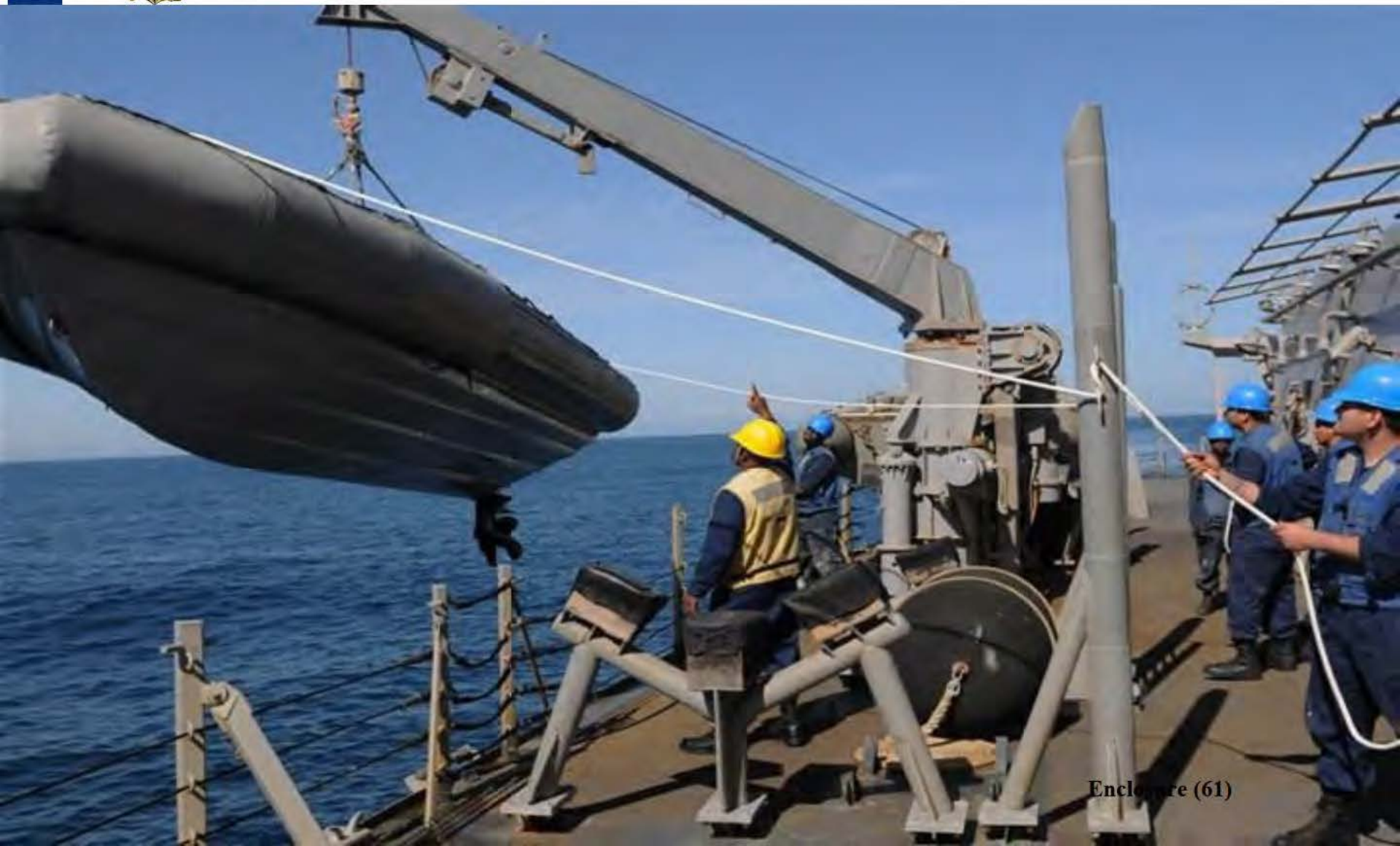
- A ship's small boats are lowered or hoisted by either a small boat davit or a crane
- There are several davit designs in use by U.S naval assets, but all designs can be divided in two categories:
  - Mechanical:
    - Slew Arm Davit
  - Gravity:
    - Double Pivot Gravity Davit

Mechanical: Slewing Arm Davit (SLAD)

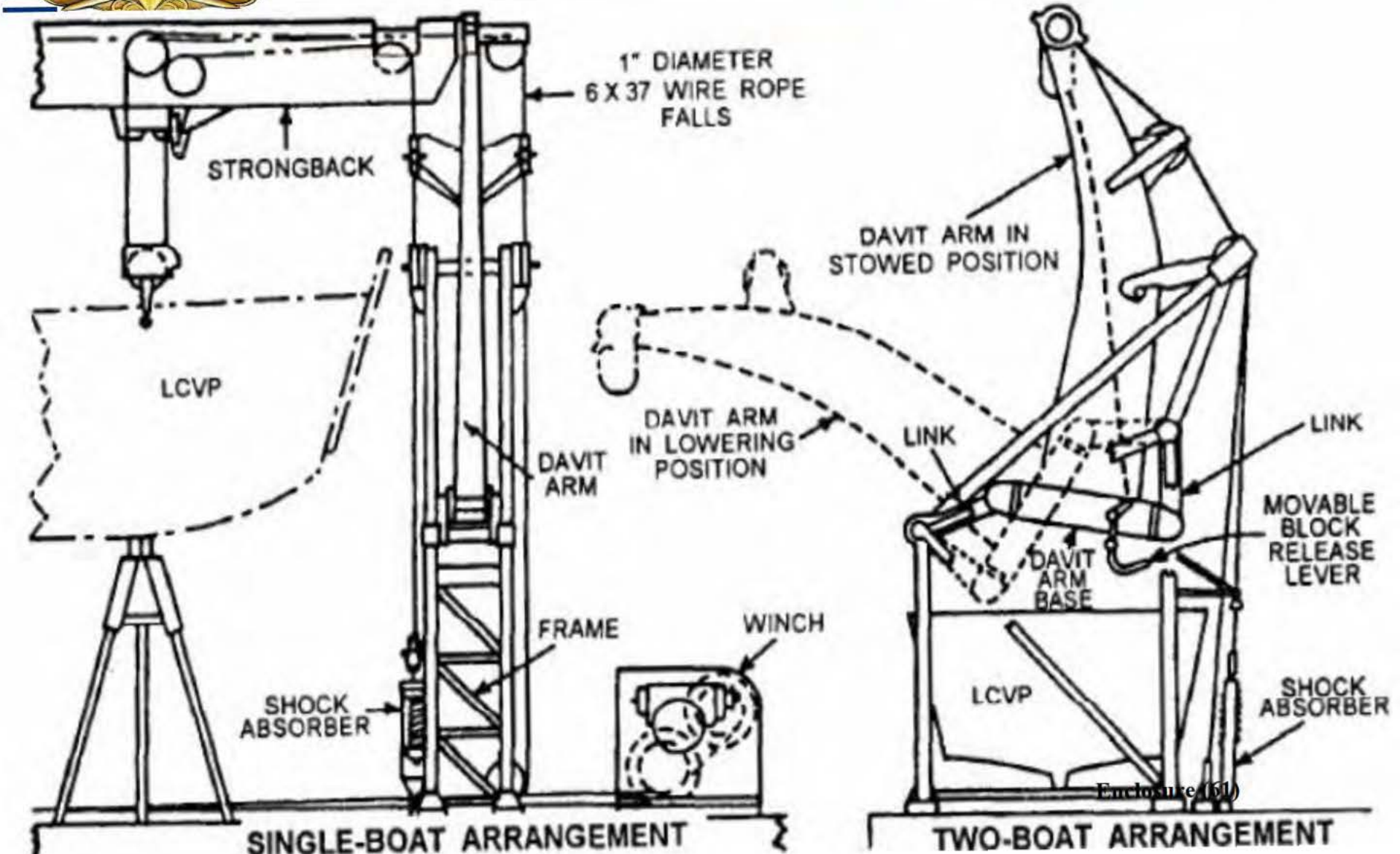


Enclosure (61)

Mechanical: Slewing Arm Davit (SLAD)



Gravity: Double Pivot Gravity Davit



Gravity: Double Pivot Gravity Davit

Enclosure (61)

Cranes and Small Boats

Enclosure (61)

Small Boat: Launching

1) Prepare the boat for launch
   - Disconnect stowage lines or gripes
   - Attach the boat sling to the davit and make ready all steadying lines
2) Lower the boat to the ship's rail
3) Embark the crew and the lower the boat via the davit or crane
   - Before the boat touches the water, the Boat Engineer must start the engine to ensure maneuverability in the water
4) Once the boat is in the water:
   - Unhook the boat sling
   - Cast off the steadying lines in the following order: AFT then FORWARD
   - Once the small boat drives forward, to ease tension on sea painter, cast off the sea painter
   - Load all passengers into the boat from the Pilot's Ladder

- **The Boat Deck must receive permission for all actions from OOD**
- **The CONN must create a lee on the side of the davit/crane and slow to 3kts**

Small Boat: Recovering

1) Disembark passengers from the small boat via the Pilot's Ladder.
2) The small boat crew secures the sea painter to the bow and allows the boat to align with the davit or crane.
3) The boat crew will attach steadying lines in the following order: FORWARD then AFT.
4) The hoisting sling is lowered and attached.
5) The small boat is raised to the rail to allow the boat crew to disembark.
6) The small boat is raised and secured in stowage by boat gripes.

- **Small boats will always request permission from the OOD to come alongside for passenger transfer and recovery.**

Small Boat Maneuvering

- Planing:
  - RHIBs are designed to hydroplane
    - Planing speed is the speed that slightly raises the boat so that it glides over, instead of ploughing through, the water
- Pivot Turns:
  - A hard turn allowing the small boat to sharply come about 180°

Enclosure (61)

Small Boat Maneuvering

- Prevention of Tripping:
  - The Coxswain manages acceleration to prevent over-speeding (tripping) of the engine
- Prevention of Airborne Manuevers:
  - The Coxswain manages the boat speed based on sea state
    - Thus preventing the small boat from becoming airborne and severely damage the boat and crew

Small Boat Etiquette

- Rendering Honors:
  - Passing:
    - As small boats with embarked officials (in view) pass each other, the Coxswain and senior officer embarked will render hand salutes
    - The Coxswain of the junior small boat will idle their engine
    - After the senior boat returns the salute, the junior boat's Coxswain can resume speed
    - Unless it is dangerous, the Coxswain of the junior boat must stand while rendering a hand salute
  - Overtaking:
    - A junior boat should never overtake a senior boat without permission
    - To request permission, the junior boat slows and salutes the senior boat
    - When the salute is returned, permission is granted to the junior boat to overtake the senior boat

Small Boat Etiquette

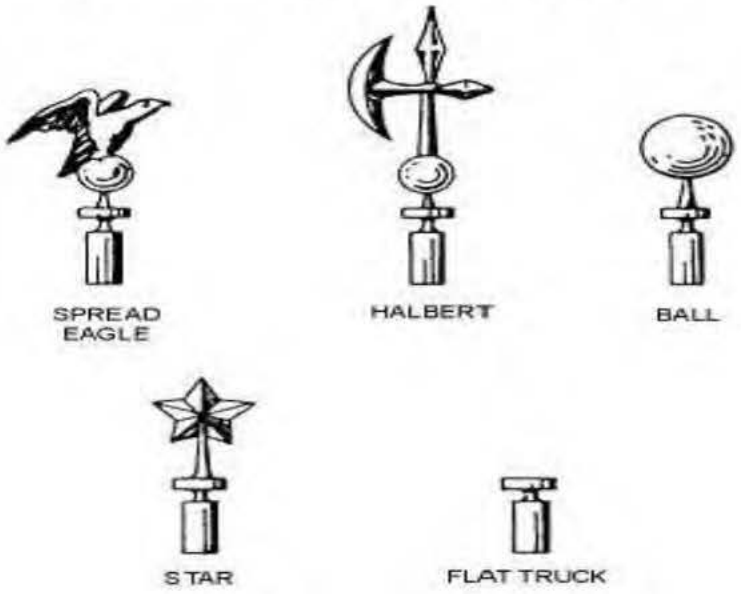
- Embarking/Disembarking:
  - As is safe an practicable, a Coxswain will stand and render a hand salute when an officer embarks or disembarks a small boat
  - Seniors will embark a boat last and disembark first and the seats farthest aft are reserved for senior officers
- Daylight Boat Hails:
  - The Officer of the Deck will raise his or her arm straight up with a clenched fist
  - The Coxswain replies by showing fingers amounting to how many side boys the most senior officer or official onboard is designated
- Night Boat Hails:
  - The Officer of the Deck will call out "Boat ahoy!"
  - The Coxswain will reply with the proper name from the NTP 13 (ser) instruction

Small Boat Etiquette

- Actions during Colors or Ceremonies:
  - The Coxswain will stop engines or proceed at the slowest safe speed
  - The Boat Officer or Coxswain will stand and salute, while the rest of the crew stands at attention
  - All passengers will sit at attention
  - The Ensign on the small boat in lowered once the boat returns to shore or ship

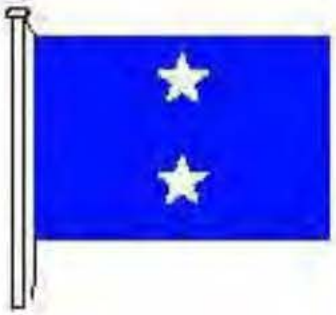
Small Boat: Flag Staff Insignia

- President: Spread Eagle
- Flag Officer: Halbert
- Captain: Ball
- Commander: Star
- Officer below Commander: Flat Truck



Small Boat Flags

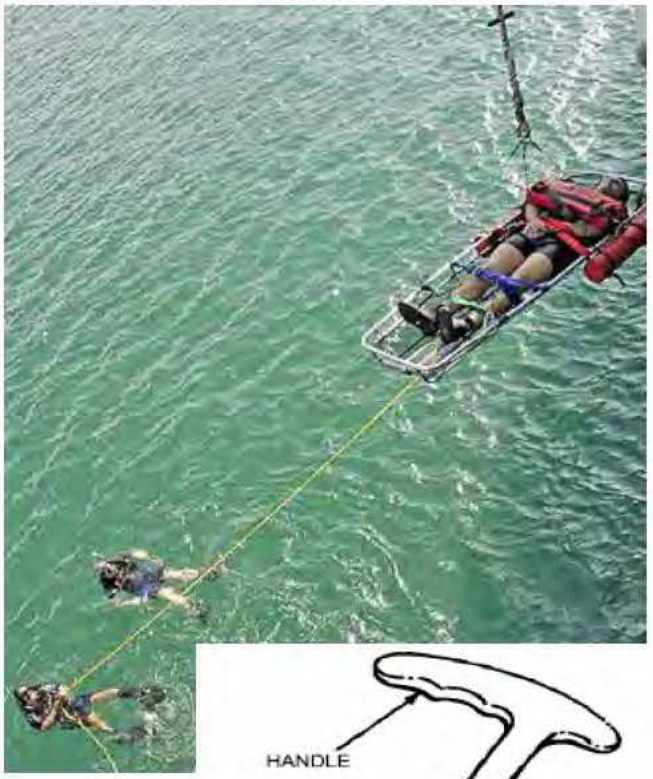
- When an embarked officer has a personal flag or pennant, it will be flown at the bow of the small boat

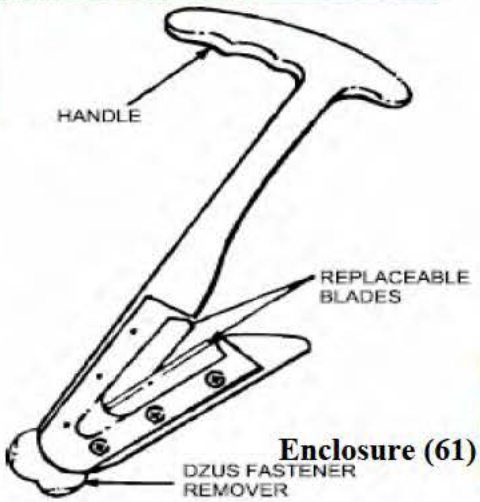


Small Boat: Rescue Boat Procedures

Small Boat: Rescue Boat Equipment

- Boat Hook
- Life Ring
- Battle Lanterns
- Medical Kit
- Rifle – Shark watch
- SAR MEDEVAC Litter
- Swimmer Tending Line
- Radio set (BTB and Portable)
- Flashlights
- V-Bladed Rescue Knife
- Heaving Lines
- Grapnel Hook





Enclosure (61)

Small Boat: Rescue Boat Crew

- Rescue Boat Crew:
  - Mandatory additions to the normal small boat crew are a Boat Officer and Search and Rescue (SAR) swimmer
  - Optional crew members include a Corpsman or Gunner's Mate (Shark Watch)
- Search and Rescue (SAR) Swimmer:
  - Each ship is required to have two qualified, with current certifications, SAR swimmers
  - The SAR swimmer must have the SAR Swimmer NEC
  - SAR swimmers are specially trained to recover a overboard individuals from a ship or small boat (RHIB)
  - SAR swimmers have the following basic gear: Wet/Dry suit, swim fins, snorkel and mask, lifting harness, light, and dive knife

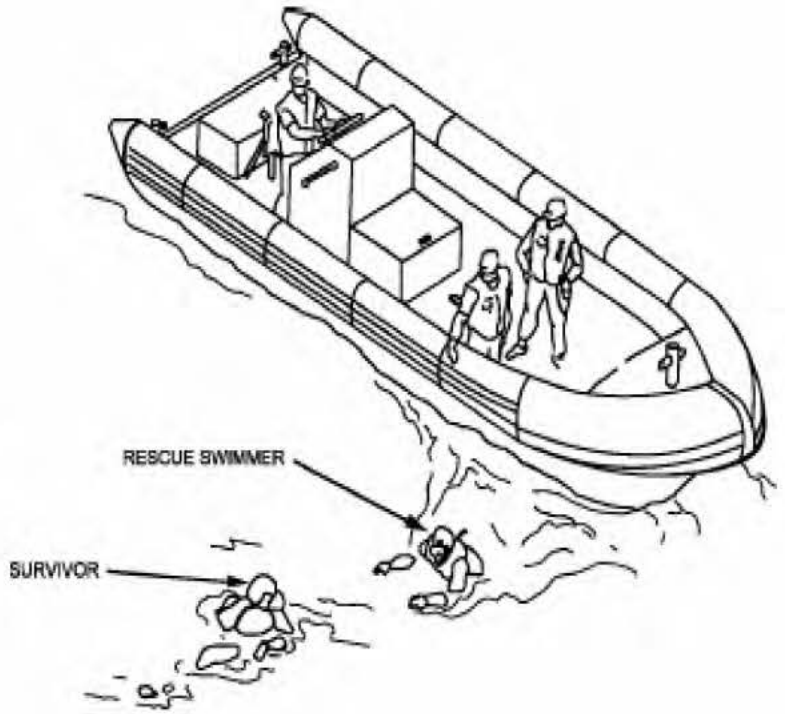
SAR Swimmer Signals

- Day Signals:
  - "I am alright.": Arm raised above head with flat palm
  - "Ready for pickup.": Raised arm, thumb up
  - "In trouble, need assistance.": Vigorous waving of one arm
  - "Heave around.": Raised arm, thumb up, trail line in hand

- Night Signals:
  - "I am alright.": Arm raised straight with a chem light
  - "Ready for pickup.": Waving a chem light
  - "Need Assistance.": Waving a flare or a blue strobe light

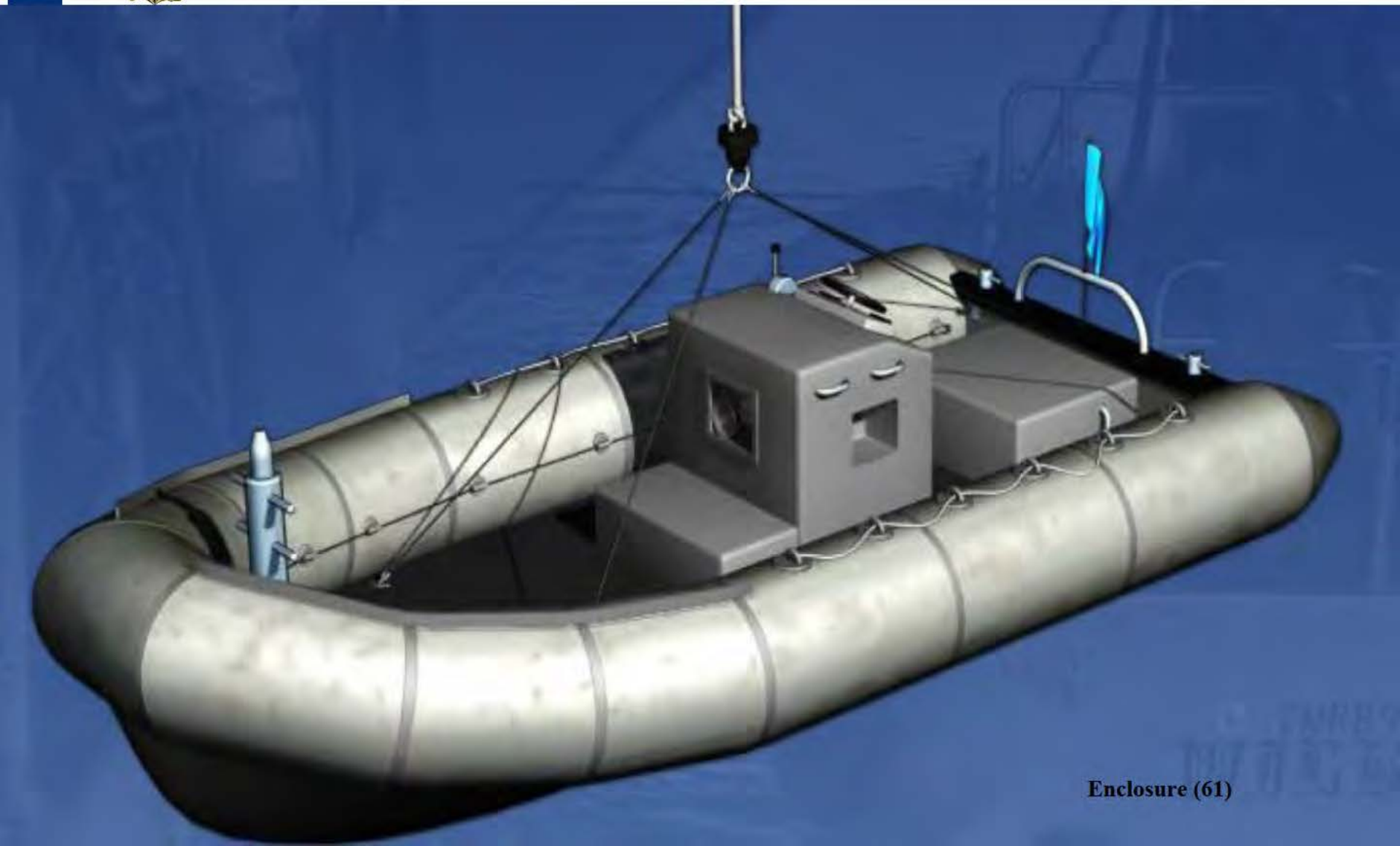
Approaching a Survivor

- The small boat approach should be made directly at the survivor, keeping the survivor on the port bow until the SAR swimmer is deployed off the starboard bow
- Once the SAR swimmer has positive control of the survivor and signals, the small boat will come alongside the survivor
- To prevent back injury, survivors should be recovered facing outboard on a small boat



Knowledge Check

Review



Enclosure (61)

27 Jul 18

From: (b)(6) Investigating Officer
To: Commander, Destroyer Squadron TWO EIGHT

Subj: COMMAND INVESTIGATION INTO THE DEATH OF ENS SARAH JOY MITCHELL, USN, AT SEA, ON 8 JULY 2018

Ref: (a) JAGINST 5800.7F, Chapter 2
(b) S9008-JL-BIB-010 BIB (Boat Information Book) on 7M RIBs
(c) JASONDUNHAMINST 9583.1E Boat Bill
(d) COMNAVSURFLANT 261355Z APR 18
(e) NAVEDTRA 14343A Boatswain's Mate
(f) NAVEDTRA 43152-L Personnel Qualification Standard for Forces Afloat Small Boat Operations
(g) S9086-TX-STM-010 Boats and Small Craft
(h) ATGLANTINST 3502.1A Annex R Deck Seamanship (MOB-S) ATGLANT User's Guide
(i) COMNAVSURFORINST 3500.5 Watchstander's Guide
(j) COMNAVSURFPACINST 1500.1/COMNAVSURLFANTINST 1500.1
(k) NTTP 3-50.1 Navy Search and Rescue Manual

Encl: (1) Appointing Order dtd 9 Jul 18
(2) Voluntary Statement of (b)(6) dtd 13 Jul 18
(3) (b)(6) email of 25 Jul 18
(4) Voluntary Statement of (b)(6) dtd 13 Jul 18
(5) Voluntary Statement of (b)(6) dtd 13 Jul 18
(6) JASON DUNHAM Plan of the Day of 8 Jul 18
(7) Voluntary Statement of (b)(6) dtd 13 Jul 18
(8) Voluntary Statement of (b)(6) dtd 13 Jul 18
(9) Voluntary Statement of (b)(6) dtd13 Jul 18
(10) Voluntary Statement of (b)(6) dtd 13 Jul 18
(11) Voluntary Statement of (b)(6) dtd 12 Jul 18
(12) Voluntary Statement of (b)(6) dtd 12 Jul 18
(13) Voluntary Statement of (b)(6) dtd 13 Jul 18
(14) Voluntary Statement of (b)(6) dtd 20 Jul 18
(15) Voluntary Statement of (b)(6) dtd 11 Jul 18
(16) Voluntary Statement of (b)(6) dtd 11 Jul 18
(17) JASON DUNHAM Deck Log of 8 Jul 18
(18) Voluntary Statement of (b)(6) dtd 13 Jul 18
(19) RHIB Launch/Recovery Checklist dtd 8 Jul 18
(20) Voluntary Statement of (b)(6) dtd 13 Jul 18
(21) Voluntary Statement of (b)(6) dtd 13 Jul 18
(22) JASON DUNHAM Watchbill for 6-12 Jul 18
(23) JASON DUNHAM Condition III Watchbill effective 24 Jun 18 to 8 Jul 18
(24) Voluntary Statement of (b)(6) dtd 12 Jul 18
(25) Voluntary Statement of (b)(6) dtd 12 Jul 18
(26) Voluntary Statement of (b)(6) dtd 13 Jul 18
(27) JASON DUNHAM Daily Boat Report from 7 Jul 18
(28) Voluntary Statement of (b)(6) dtd 11 Jul 18
(29) Voluntary Statement of (b)(6) dtd 11 Jul 18
(30) Voluntary Statement of (b)(6) dtd 11 Jul 18
(31) Voluntary Statement of (b)(6) dtd 13 Jul 18
(32) Voluntary Statement of (b)(6) dtd 11 Jul 18

(33) JASON DUNHAM Flight Schedule of 8 Jul 18
(34) Voluntary Statement of (b)(6) dtd 12 Jul 18
(35) Voluntary Statement of (b)(6) dtd 13 Jul 18
(36) Voluntary Statement and Rights advisement of (b)(6) dtd19 Jul 18
(37) JASON DUNHAM CIC Watchlog starting 0757 13 Jun 18 to 1605 08 Jul 18
(38) Voluntary Statement of (b)(6) dtd 13 Jul 18
(39) OOD letters for (b)(6) of 1 Jul 18 and 15 Mar 17
(40) JASON DUNHAM photographs from 8 Jul 18
(41) Voluntary Statement of (b)(6) dtd 12 Jul 18
(42) Voluntary Statement of (b)(6) dtd 13 Jul 18
(43) Voluntary Statement of (b)(6) dtd 19 Jul 18
(44) JASON DUNHAM video from 8 Jul 18
(45) Photographs taken by the investigating officer on 13 Jul 18
(46) JASON DUNHAM's Medical records of ENS Mitchell dtd 8 Jul 18
(47) Royal Medical Services Prince Hashem Hospital records of ENS Mitchell dtd 8 Jul 18
(48) Voluntary Statement of (b)(6) dtd 13 Jul 18
(49) Voluntary Statement of (b)(6) dtd 19 Jul 18
(50) PQS Qualification Finder for JASON DUNHAM dtd 11 Jul 18
(51) JASON DUNHAM Junior Officer qualifications tracker as of 11 Jul 18
(52) NAVPERS 1070/613 ICO ENS Mitchell dtd 24 Jul 18
(53) Surface Rescue Swimmer Designation Checklist of (b)(6)
(54) Surface Rescue Swimmer Designation Checklist of (b)(6)
(55) Designation as Surface Search and Rescue Swimmer Officer ICO (b)(6) dtd 10 Apr 18
(56) Voluntary Statement of (b)(6) dtd 18 Jul 18
(57) Voluntary Statement of (b)(6) dtd 18 Jul 18
(58) SFTM Formal Course Requirements for All Ships, COMNAVSURFPAC/LANTINST 2502.3 dtd 09 Mar 12
(59) FY 2017/2018/2019 7M RIB Coxswain School Schedule, All Sites
(60) (b)(6) email of 24 Jul 18

Preliminary Statement

1. Pursuant to enclosure (1) and in accordance with reference (a), a command investigation was conducted to investigate the facts and circumstances surrounding the death of ENS Sarah Joy Mitchell, USN at sea on 8 July 2018. All persons questioned cooperated fully. The only evidentiary challenge was records from Optical Sight System (OSS) were not available for review. No request for extension was needed.

2. Photographs were taken by the Investigating Officer and by the JASON DUNHAM photographer. The Investigating Officers photographs were taken using a Samsung Galaxy 9 and are a true and accurate representation of the items depicted. The JASON DUNHAM photographer used a Nikon D5; the pictures and video are true and accurate representations of the items depicted.

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

3. Personnel contacted:

RANK	NAME	POSITION/TITLE	CONTACT INFO
(b)(6)	(b)(6)	(b)(6)	(b)(6)
		Boat Deck Safety Officer	
		Boat Engineer	
		Boat Engineer	
		Boat Engineer (U/I)	
		Boat Engineer (U/I)	
		Boat Officer (U/I)	
		Boat Officer (U/I)	
		Boat Officer (U/I)	
		Boat Officer (U/I)	
		Chief Engineer	
		Combat Systems Officer	
		Command Master Chief	
		Commanding Officer	
		Coxswain	
		Coxswain	
		CSCS Instructor	
		CSCS Instructor	
		Executive Officer	
		First Lieutenant; Boat Officer	
		Independent Duty Corpsman	
		Officer of the Deck (OOD)	
		Operations Officer	
		Passenger	
		Passenger	
		Passenger	
		Passenger	
		Passenger	
		Passenger	
		Passenger	
		Rescue Swimmer	
		SAR Swimmer	
		SAR Swimmer	
		Training Officer	

Executive Summary

At approximately 0910 and 0924 on 8 July 2018, USS JASON DUNHAM (DDG 109) launched two Rigid Inflatable Boats (RIBs) with call signs: RIB BILLY HAMPTON and RIB KELLY MILLER. Each RIB conducted two trips with the same crew but different passengers. On the second trip, RIB BILLY HAMPTON had eleven personnel on board, including a Boat Officer, ENS Sarah Joy Mitchell, USN, Coxswain, Search and Rescue (SAR) swimmer, Boat Engineer, two Boat Officers (under instruction U/I), one Boat Engineer (under instruction U/I), and four Midshipmen.

After breaking away from the starboard side of JASON DUNHAM, RIB BILLY HAMPTON transited astern of JASON DUNHAM before initiating four to five S curves. RIB BILLY HAMPTON was heading towards a station off of the port bow at full throttle. The coxswain decided to execute a donut by applying full rudder to port. He maintained full throttle. RIB BILLY HAMPTON tripped, its outdrive semi exiting the water. When the RIB hit the water, the jolt ejected four personnel off the starboard side. ENS Mitchell was among the personnel ejected from the starboard side. The coxswain was almost thrown off the helm by the jolt and was unable to put the RIB in neutral and turn to starboard before the RIB passed over ENS Mitchell, severely injuring her head and ripping off her lifejacket. Man overboard was reported via bridge to bridge at time of 1021.

The SAR swimmer, (b)(6) deployed himself immediately by letting go of the RIB as it was still turning, and swam towards the personnel in the water. (b)(6) focused on assisting ENS Mitchell, who he found injured and face down in the water. (b)(6) rolled ENS Mitchell onto her back and towed her back to RIB BILLY HAMPTON. Once ENS Mitchell was on board the RIB, (b)(6) (b)(6) immediately began treating her. RIB KELLY MILLER, which had been conducting training separately, ceased its training operations to assist RIB BILLY HAMPTON. After RIB KELLY MILLER arrived on station, it came alongside RIB BILLY HAMPTON. RIB BILLY HAMPTON was dead in the water; its propeller was fouled with ENS Mitchell's lifejacket. The RIB crews transferred ENS Mitchell to RIB KELLY MILLER to return her immediately to JASON DUNHAM for medical treatment.

During the transit back to JASON DUNHAM, (b)(6) dressed ENS Mitchell's wounds before performing chest compressions and rescue breathing on her. After reaching JASON DUNHAM, ENS Mitchell was lifted on board via a litter where medical treatment, including chest compressions and rescue breathing, continued as she was transferred to the ship's helicopter for medical evacuation. The helicopter departed JASON DUNHAM at approximately 1130. ENS Mitchell was pronounced dead at 1245 by medical staff at Prince Hashem bin Abdullah II hospital in Aqaba, Jordan.

Findings of Facts

I. Planning and Scheduling of Small Boat Operations on 8 July 2018

1. JASON DUNHAM scheduled small Boat Officer training for 6 July 2018 during the Planning Board for Training held on 3 July 2018. [Encl (2)]

2. This was the second time that JASON DUNHAM conducted small boat operations since deploying on 2 June 2018. [Encl (3)]

3. The 6 July 2018 evolution was canceled because the sea state was not conducive to operating small boats. [Encls (2), (4), (5), (21)]

4. Small boat operations were rescheduled after 6 July when (b)(6) Training Officer, recommended it be reincorporated into the schedule for 8 July 2018. [Encl (4)]

5. (b)(6) Operations Officer, then made recommendations on 7 July 2018 small boat operations be included in the Plan of the Day (6) for 8 July 2018. [Encl (4)]

6. The Weapons Officer requested the Visit Board Search Seizure (VBSS) training be added to the evolution, which (b)(6) Commanding Officer (CO), approved. [Encl (2)]

7. On 7 July 2018, it was briefed at the Operations Intelligence Brief JASON DUNHAM would conduct small Boat Officer and VBSS training. [Encl (4)]

8. The JASON DUNHAM POD for 8 July 2018, released on 7 July 2018, called for Small Boat Officer training and VBSS training. [Encl (6)]

9. Most participants learned there would be small boat operations on 8 July 2018 upon reading the POD on 7 or 8 July 2018. [Encls (7), (8), (9), (10), (11), (12), (13), (14)]

10. The Midshipmen were informed they would be participating in small boat operations during their morning meeting with (b)(6) and were reminded with an announcement over the 1MC on 8 July 2018. [Encls (15), (16)]

11. On 8 July 2018, man the boat deck was announced over the 1MC at approximately 0849. [Encls (17), (18), (19)]

a. Identifying the Boat Crew and Boat Deck Safety Officer

12. Concurrent flight and small boat operations, particularly with two RIBs in the water, requires the participation of all of Deck Division. [Encls (7), (11)]

13. (b)(6) one of the JASON DUNHAM Search and Rescue (SAR) swimmers, learned of the small boat operations at CE division quarters at approximately 0815 on 8 July 2018 when the (b)(6) (b)(6) (b)(6) walked by and asked him if he had heard about boat operations that day. [Encl (20)]

14. (b)(6) and (b)(6) Deck Division Leading Chief Petty Officer (LCPO), were "sour" and "annoyed", respectively, they had to prepare for the boat evolution on such short notice. [Encls (7), (11)]

15. Although not a "show stopper" for (b)(6) the schedule change cost his boat crew members a two-hour nap that they would normally take after standing the midwatch. [Encl (11)]

16. There are four positions that must be filled in each RIB in accordance with references (b) and (c): Coxswain, Bowhook, Engineer, and SAR Swimmer, but JASON DUNHAM routinely swaps in a Boat Officer for Bowhook and all Boat Officers are qualified in that job function. [Encls (2), (21)]

17. (b)(6) designated himself as the first boat officer, then had to find a second Boat Officer. (b)(6) approached two other qualified Boat Officers before contacting ENS Mitchell, who volunteered. [Encls (6), (7), (22), (23)]

18. (b)(6) and ENS Mitchell both had watch from approximately 0330 to 0700 on 8 July 2018. [Encls (7), (22)]

19. (b)(6) knew in filling the positions of each crew on each RIB that (b)(6) would be a coxswain for the VBSS RIB while (b)(6) would coxswain the second RIB, due to the Flight Operation watchbill requirements for his other qualified coxswain. [Encls (11), (12)]

20. (b)(6) one of the JASON DUNHAM SAR Swimmers, and (b)(6) decided amongst themselves who would take the VBSS RIB and who would take the RIB conducting Boat Officer training. [Encl (20)]

21. ENS Mitchell was (b)(6) division officer. [Encl (20)]

22. (b)(6) was the Boat Deck Safety Officer on 8 July 2018. [Encl (11)]

b. Pre-evolution briefs and guidance

23. There was no separate planning brief specifically for Boat Officer training. [Encls (15), (20), (24), (25)]

24. Personnel reported there was no guidance on how to specifically conduct Boat Officer training. [Encls (4), (9)]

25. There was mixed reports as to whether or not there was an organized safety brief on the boat deck. (b)(6) Executive Officer (XO) stated there was a pre-event safety brief given by First Lieutenant prior to launching the RIBs. [Encls (2), (7)]

26. The Daily Boat Report was reviewed. (b)(6) passed out lifejackets to everyone and helmets to the U/I Boat Officers. He also directed everyone to take off their watches and empty their pockets. [Encls (7), (8), (16), (18), (26), (27)]

27. (b)(6) gave (b)(6) Boat Officer (U/I), (b)(6) Boat Officer (U/I), and (b)(6) Boat Officer (U/I), a quick brief on how to be in a RIB, which included line handling and SAR hand signals. [Encl (10)]

28. Although (b)(6) preferred to focus on training Boat Officers, he received direction on the boat deck on the morning of 8 July 2018 from his Department Head (b)(6) the Operations Officer, to include Midshipmen in the small boat operations. [Encls (4), (7)]

29. One Midshipman recalled someone saying, small boat operations "is what we do to convince you to go SWO." [Encl (28)]

30. (b)(6) divided the under instruction (U/I) crew members and midshipmen into two groups of passengers, with a goal of two U/I Boat Officers per RIB and no more than 10 passengers per RIB. [Encls (7), (8), (10), (14), (28), (29)]

31. When planning for a boat evolution that was scheduled for 6 July, (b)(6) (b)(6) and (b)(6) had discussed limiting the number of personnel on the RIB to fewer than 10 because of the inexperience of the passengers. [Encl (11)]

32. After (b)(6) assigned the groups, two more people joined the group on RIB BILLY HAMPTON than assigned. [Encls (7), (10)]

33. Some of the Midshipmen learned how to climb the ladder down to the RIB about a week and a half before 8 July 2018 when JASON DUNHAM had previously conducted small boat operations. [Encl (16), (28), (30)]

34. Each RIB had two midshipmen onboard, as opposed to the three midshipmen per RIB during the previous operation of small boats. RIB BILLY HAMPTON on the second trip was the exception with four midshipmen on board. [Encl (30)]

35. Both RIB KELLY MILLER and RIB BILLY HAMPTON had working fixed radios, however, there was only one working hand-held radio. (b)(6) gave this to ENS Mitchell because it was her first time performing as a fully-qualified Boat Officer and her RIB would be first in the water. [Encl (7)]

36. (b)(6) was not aware of how many passengers were on RIBs for the first time nor did he give any guidance to the boat crews on how to account for the lack of experience. [Encl (4)]

II. Execution of Small Boat Operations on 8 July 2018

37. Several participants reported that the demeanor of the participants in small boat operations was one of fun, excitement, and having a good time. The conditions were calm and the weather was pleasant. [Encls (2), (4), (5), (8), (9), (10), (12), (13), (15), (16), (20), (24), (25), (26), (29), (31), (32)]

38. The water was so clear that (b)(6) could see the screws of the JASON DUNHAM. [Encl (12)]

39. On 8 July 2018, JASON DUNHAM began flight quarters at approximately 0732 with the helicopter, Venom 506, taking off at 0802. [Encls (17), (33)]

40. The seas were calm with waves of 1-2 feet at the most, visibility was clear, current was slight, winds were light, water temperature was in the high 80s. The operating area was not shallow. [Encls (5), (8), (9), (12), (16), (21), (34)]

41. RIB BILLY HAMPTON was at the rail and the boat report was received at 0854. [Encl (17)]

42. RIB BILLY HAMPTON launched via the Slewing Arm Davit (SLAD) at approximately 0910 with ENS Mitchell on board. [Encls (7), (17)]

43. ENS Mitchell supervised as the other passengers boarded via the ladder over the side. [Encl (7)]

44. RIB KELLY MILLER was at the rail at approximately 0925 and launched at approximately 0930. [Encl (17)]

45. JASON DUNHAM was also conducting a Damage Control Training Team (DCTT) drill on the morning of 8 July 2018. [Encl (35)]

A. First Trip by RIB BILLY HAMPTON

46. ENS Mitchell; (b)(6) (b)(6) Boat Engineer; (b)(6) Boat Engineer U/I; (b)(6) reenlistment officer; a chief; (b)(6) (b)(6) (b)(6)

Boat Officer (U/I); and two additional midshipmen were on board RIB BILLY HAMPTON. [Encls (26), (31)]

47. (b)(6) and ENS Mitchell had discussed conducting a reenlistment and Boat Officer training, but did not discuss the plan or path of how to get from JASON DUNHAM to their training stations. [Encl (36)]

48. (b)(6) stated he and ENS Mitchell both agreed they were going to have some fun. He believes that meant that high-speed maneuvers were implied. [Encl (36)]

49. After breaking away, (b)(6) executed a donut 200-300 yards off of the JASON DUNHAM starboard side, within view of the boat deck. [Encl (36)]

50. (b)(6) did not like the donut (b)(6) executed. If (b)(6) had a radio, he might have said something to (b)(6) about it. [Encl (11)]

51. RIB BILLY HAMPTON traveled approximately 1000 yards away from the JASON DUNHAM before (b)(6) conducted the reenlistment ceremony for (b)(6) [Encls (9), (20), (26), (31)]

52. ENS Mitchell requested permission from the bridge over the radio for RIB BILLY HAMPTON to conduct SAR training by deploying a survivor and the SAR swimmer. [Encl (20)]

53. After about five minutes, bridge granted permission to RIB BILLY HAMPTON, assigning the RIB a station 500 yards off of the port quarter of JASON DUNHAM. [Encls (9), (20)]

54. (b)(6) executed a second donut off of the JASON DUNHAM port side while en route to their assigned station for training. [Encl (36)]

55. ENS Mitchell asked for a volunteer to be the survivor for (b)(6) to practice rescuing; (b)(6) (b)(6) volunteered. [Encls (18), (20)]

56. ENS Mitchell and (b)(6) discussed whether or not (b)(6) should keep his lifejacket (aka KAPOK) on because of the Man Overboard Indicator (MOBI) on it that would set off the ship's alerts when wet; the survivor had removed his/her lifejacket the last two times that (b)(6) participated in training. [Encl (20)]

57. ENS Mitchell decided to call the bridge to get permission to deploy the survivor without a lifejacket on. [Encl (20)]

58. ENS Mitchell provided the name of the survivor to the bridge. [Encl (20)]

59. Although (b)(6) had said that he wanted to be in the water before the survivor got in, (b)(6) (b)(6) removed his lifejacket and cannon-balled into the water before (b)(6) could deploy. [Encls (20), (29)]

60. (b)(6) reported he did not remove his lifejacket before entering the water. [Encl (18)]

61. ENS Mitchell very quickly deployed (b)(6) who then recovered (b)(6) [Encl (20)]

62. RIB BILLY HAMPTON returned to JASON DUNHAM to disembark the first set of passengers and embark the second set, which it completed at approximately 1018; the boat crew remained the same. [Encls (17), (20)]

B. First Trip by RIB KELLY MILLER

63. Once RIB KELLY MILLER was in the water and all personnel were on board, the RIB broke away and traveled away from the ship. [Encl (7)]

64. The helicopter passed over RIB KELLY MILLER a few times. The RIB mirrored the helicopters maneuvers. [Encls (7), (12)]

65. (b)(6) executed pivot turns and speed changes. [Encl (12)]

66. At the conclusion of VBSS training, the RIB returned to JASON DUNHAM to offload passengers and onload a new set of passengers. [Encl (12)]

C. Second trip by RIB KELLY MILLER

67. After breaking away from JASON DUNHAM, (b)(6) requested permission from the Officer of the Deck (OOD) to conduct SAR training. [Encl (7)]

68. The request was made while the RIB was traveling away from JASON DUNHAM, going quickly and executing turns. [Encl (13)]

69. (b)(6) observed that (b)(6) slowed down to execute each turn before speeding up again. [Encl (13)]

70. (b)(6) was going to be the survivor for the SAR swimmer to rescue as he had volunteered and (b)(6) knew that he was a qualified second class swimmer. [Encls (7), (13)]

71. After a few minutes, the OOD approved the request but directed RIB KELLY MILLER to a station 1000 or 2000 yards off of the starboard bow. [Encl (7)]

72. While RIB KELLY MILLER transited to its station, (b)(6) and (b)(6) heard "man overboard, man overboard" via the radio. [Encls (7), (12)]

73. At the time of the radio call, (b)(6) estimated that RIB KELLY MILLER was about 500 meters off the starboard quarter of JASON DUNHAM while the RIB BILLY HAMPTON was about 700 meters away from the JASON DUNHAM. [Encl (15)]

74. The crew on RIB KELLY MILLER initially believed this meant RIB BILLY HAMPTON had already started the same drill. [Encl (7)]

D. Second Trip by RIB BILLY HAMPTON

75. Figures 1 and 2 are diagrams of a 7M RIB. Personnel were arranged on RIB BILLY HAMPTON as follows:

a. Starboard side:

i. (b)(6) SAR Swimmer, was the forward-most passenger and sat on the starboard sponson. [Encls (20), (28)]

ii. ENS Mitchell, Boat Officer was the second furthest forward on the starboard sponson. [Encl (28)]

iii. (b)(6) sat to ENS Mitchell's left. [Encls (16), (28)]

iv. (b)(6) U/I Boat Officer, sat to the left of (b)(6). [Encls (10), (28)]

v. (b)(6) U/I Boat Officer, sat on the starboard sponson with his feet propped up against the helm. [Encls (8), (28)]

vi. (b)(6) U/I Boat Engineer, sat on the starboard sponson to (b)(6) left. [Encls (14), (26), (28)]

b. Port side:

i. (b)(6) was the forward-most passenger seated on the port-side sponson. [Encls (28), (29)]

ii. (b)(6) was seated on (b)(6) right. [Encls (28), (29)]

iii. (b)(6) was seated on (b)(6) right and next to (b)(6) [Encls (14), (28), (30)]

iv. (b)(6) U/I Boat Officer, was seated on (b)(6) right. [Encls (14), (28)]

c. (b)(6) Boat Engineer, was on the storage box between (b)(6) and (b)(6) [Encl (14)]

d. (b)(6) Coxswain, was at the console. [Encls (9), (28)]

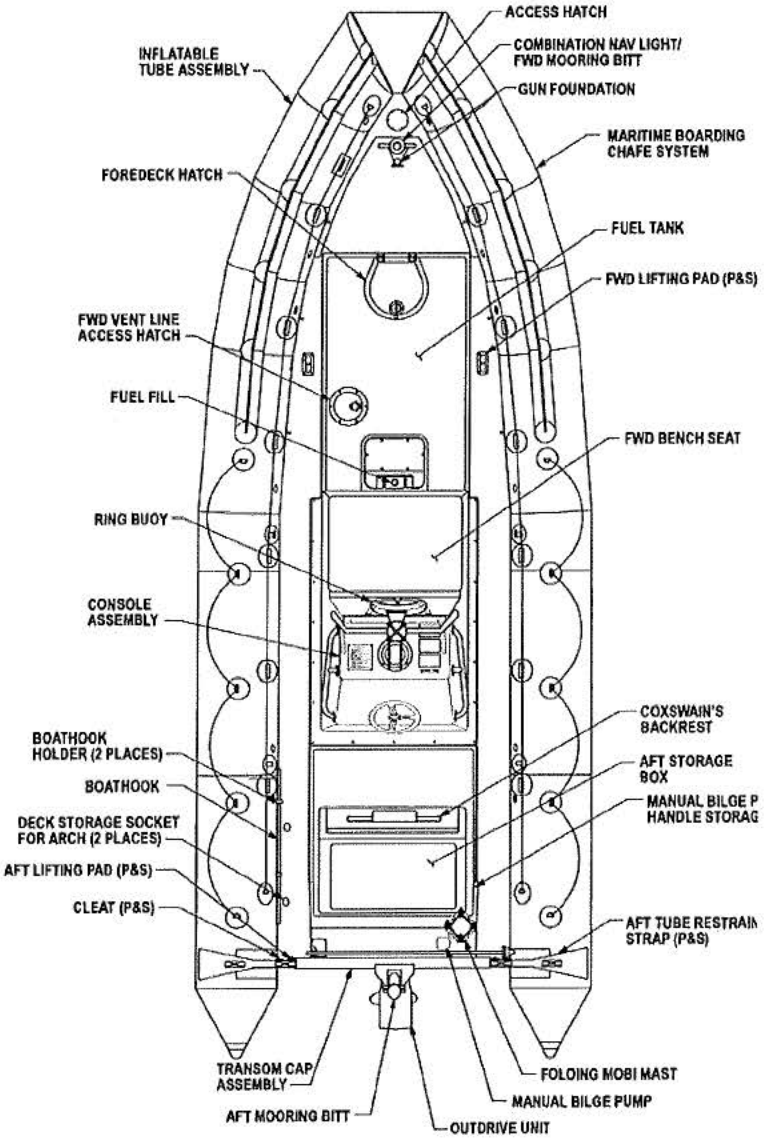


Figure 1, sourced from Reference (b)

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e. There were five people sitting along the starboard side of the RIB. [Encls (8), (20)]

f. There were two additional passengers on board during the second trip versus the first one. [Encl (9)]

g. (b)(6) and (b)(6) rebalanced personnel within the RIB. [Encl (10)]

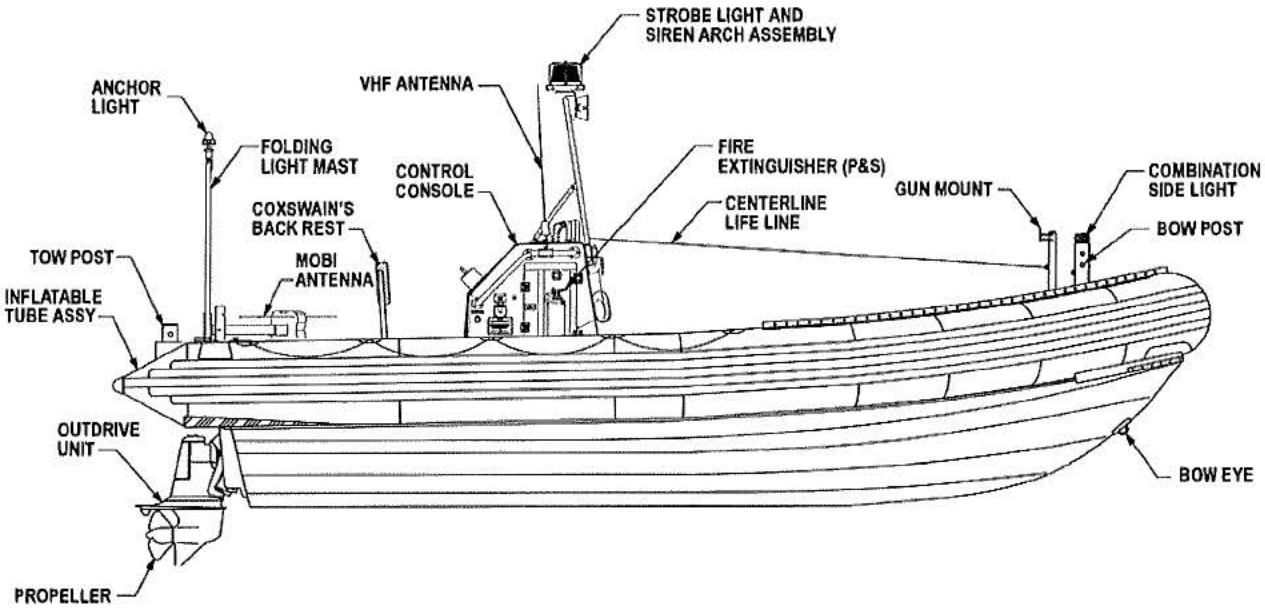

Figure 2, sourced from reference (b)

76. (b)(6) reported that he and ENS Mitchell planned on doing the same training with the second RIB ride as they had done during the first RIB ride. [Encl (36)]

77. Immediately before breaking away, ENS Mitchell directed personnel to hold onto the inboard line, see figures 1 and 3, between their legs when seated on the sponson. [Encls (28), (29)]

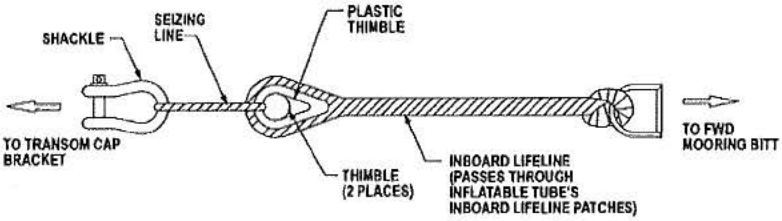

Figure 3, Diagram of inboard lifeline, sourced from reference (b)

78. After breaking away, RIB BILLY HAMPTON traveled astern of JASON DUNHAM, crossing the wake, before initiating approximately four turns in an "s" pattern. [Encls (8), (9), (10), (14)]

79. Crew members stated that coxswains like to show off and do tight, evasive maneuvers. [Encls (25), (31)]

80. (b)(6) did not feel these turns were unsafe or atypical for a RIB to execute. [Encl (8)]

81. After getting about 400 yards off of JASON DUNHAM's port quarter and observing personnel were holding on, (b)(6) executed a hard turn to port, which was the beginning of a donut. [Encls (9), (30)]

82. (b)(6) stated that at the time of the turn he was applying full throttle and estimated he was traveling approximately 20 mph when he initiated the turn. [Encls (9) (36)]

83. (b)(6) had no concerns about executing a high speed donut on 8 July 2018 because of the sea state. [Encl (9)]

84. Some personnel, including (b)(6) were not certain but thought the turn might have been announced. [Encls (9), (26)]

85. Other personnel did not hear the hard turn get announced. [Encls (8), (31)]

86. Multiple personnel reported feeling a "jolt", "impact" and that the RIB "popped", "slipped", "was jarred", "flat bottomed" about 90 to 180 degrees through the turn to port, immediately preceding the ejection of four personnel, followed by (b)(6). [Encls (8), (9), (20), (31)]

87. ENS Mitchell, (b)(6) (b)(6) and (b)(6) were all ejected from RIB BILLY HAMPTON. [Encls (8), (9), (16), (20), (31)]

88. (b)(6) reported that although he is accustomed to riding a RIB, he let go of his hold on the RIB when he observed personnel go overboard. He is not certain if he would have been able to stick with the RIB had he not let go. [Encl (20)]

89. (b)(6) described his thought process as, "They are in the water, so I am in the water." He was the fifth person to go in the water. [Encl (20)]

90. (b)(6) had never experienced anything like this before. He described the impact as analogous to the feeling of a RIB flat-bottoming in heavy seas. [Encl (9)]

91. The water was not shallow, there was nothing around, no marine life. The water was clear and undisturbed. [Encls (9), (31)]

92. (b)(6) reported seeing a two-and-a-half-foot wave immediately before being ejected, which he thought was the RIB's wake. [Encl (26)]

93. (b)(6) was the only person seated on the starboard side of the RIB who did not fall in. [Encl (8)]

94. (b)(6) fell into the center of the RIB from the port side towards the helm, bumping her head. [Encls (28), (30)]

95 (b)(6) helped (b)(6) back up. [Encls (14), (30)]

96. (b)(6) was almost thrown off of the helm. His hand was thrown free of the throttle. [Encls (9), (28)]

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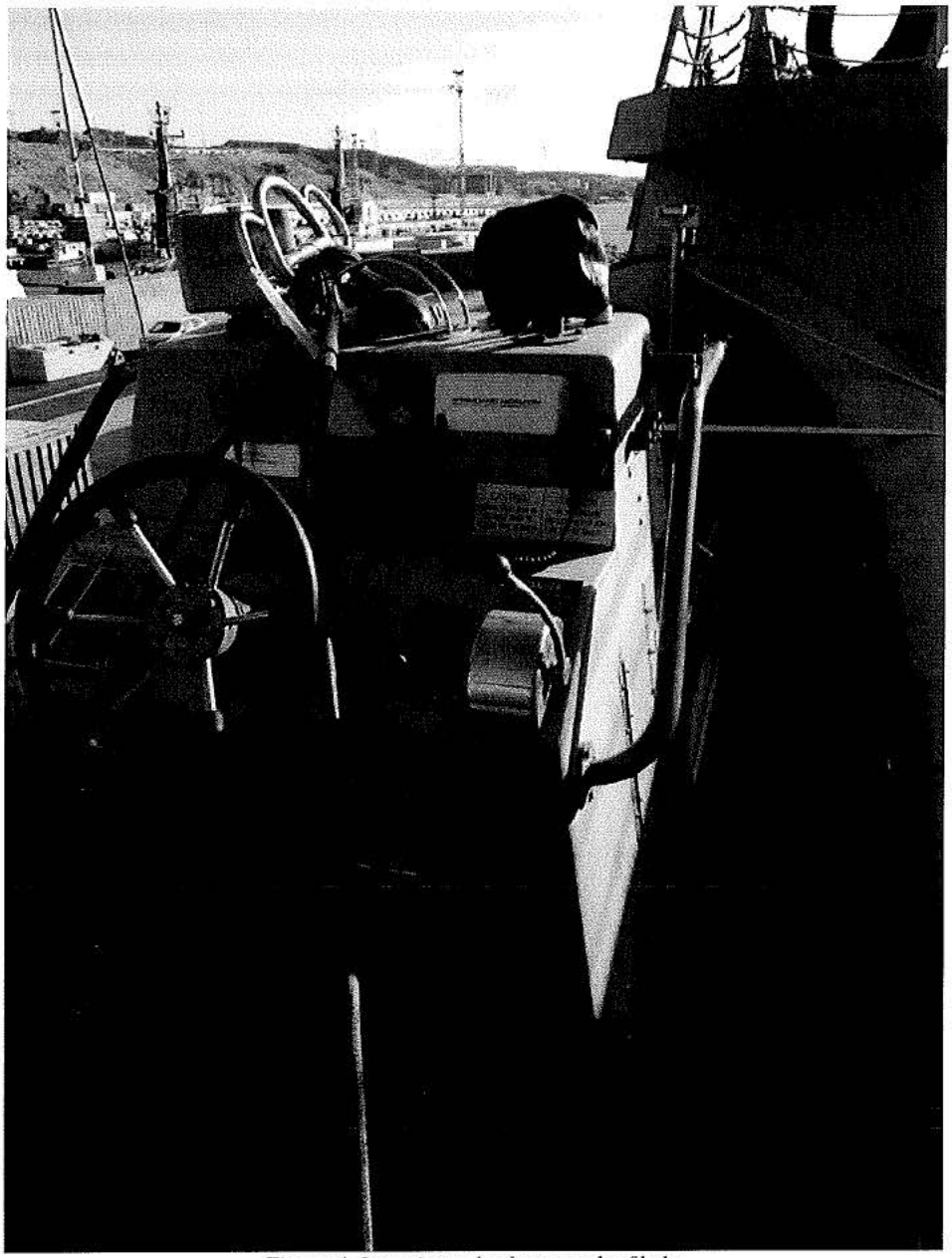

Figure 4, Investigator's photograph of helm

97. (b)(6) pulled himself up using the helm and started the turn to starboard to straighten out. He was not able to pull back the throttle before there was a second impact. [Encl (9)]

98. Immediately after the hard turn and the five personnel were ejected, the RIB came to a complete stop. [Encls (8), (31)]

III. Rescue effort

A. Recovery of ENS Mitchell from the water

99. After the RIB came to a stop, the remaining personnel onboard RIB BILLY HAMPTON started looking in the water for people. They reported observing one person floating face down in the water, who

was later identified as ENS Mitchell, (b)(6) and three people in lifejackets: (b)(6) (b)(6) (b)(6) and (b)(6) [Encls (8), (28), (29), (31)]

100. "Man overboard" was reported from RIB BILLY HAMPTON at approximately 1021. [Encls (17), (37)]

101. When (b)(6) overheard the call of "man overboard" on a radio, he began having the crew prepare to recover the RIBs as he thought boat operations would be secured shortly thereafter. [Encl (11)]

102. The helicopter off of JASON DUNHAM flew over the scene. (b)(6) Rescue Swimmer, observed three personnel in the water with lifejackets and a fourth lifejacket floating in the water. [Encl (38)]

103. Combat Information Center (CIC) did observe some of the activity over Forward Looking Infrared Radar (FLIR) but it was very poor quality. [Encl (5)]

104. Optical Sight System (OSS) was not available from 8 July 2018. The ship was unable to locate records from that day and (b)(6) Combat Systems Officer, believes the system might not have been reconfigured for underway operations after leaving a port call in Haifa, Israel. [Encl (5)]

105. The call of "man overboard" also prompted (b)(6) OOD, to direct the BMOW to call the "Captain to the pilot house" over the 1MC. TRAINO also came to the pilot house in response to the call and directed a training time out for the Damage Control Training Team (DCTT) drill JASON DUNHAM was running. [Encls (34), (39)]

106. XO called the bridge when he heard over the 1MC, "Captain to the Pilot House," and heard a person had fallen off of a RIB and was being recovered, so he thought the situation was not emergent. [Encl (2)]

107. (b)(6) ejected close enough to ENS Mitchell to see she was floating upside down and attempted to reach her leg to flip her over. Upon seeing all of the blood, (b)(6) was unable to take further action. [Encl (16)]

108. (b)(6) estimates he ejected approximately five yards from the RIB and approximately 20 yards from the other personnel. [Encl (20)]

109. (b)(6) estimated the ejected personnel were about 100 yards away from the RIB. [Encl (9)]

110. (b)(6) ejected with his mask and snorkel but without his fins; his snorkel detached in the process of ejecting, so he discarded both before swimming to the survivors. [Encl (20)]

111. (b)(6) reached ENS Mitchell before getting to the other survivors; she was closer to him than the other three personnel. She did not have a lifejacket and was surrounded by blood. [Encls (8), (20), (40)]

112. (b)(6) asked the others if they were okay. (b)(6) started screaming, "Blood!" while waving her hands. [Encl (10)]

113. (b)(6) tried to apply throttle to get the RIB closer to the ejected personnel, but every time he did, there was a knocking sound and the helm shook. [Encl (9)]

114. (b)(6) called the bridge to report the medical casualty. [Encl (8)]

115. (b)(6) stepped up to take direction of RIB BILLY HAMPTON. [Encl (20)]

116. Using the high-powered binoculars, the CO knew something was really wrong when he saw someone, who he did not yet know was ENS Mitchell, was limp and being assisted into the RIB without attempting to climb back in herself. [Encl (21)]

117. Around this time, (b)(6) told (b)(6) to leave the bridge wing and use the fixed radio because the handheld was not as reliable. (b)(6) then took over the handheld VHF. [Encl (4)]

118. (b)(6), the Tactical Action Officer (TAO) on watch, began communicating with CTF 55 via chat about the need to execute a Medical Evacuation (MEDEVAC) for ENS Mitchell. [Encl (5)]

119. Some of the other personnel onboard RIB BILLY HAMPTON started waving at the JASON DUNHAM for help. [Encl (28)]

120. (b)(6) and (b)(6) inspected the propeller by bringing the trim of the outdrive up. Prior to the inspection, (b)(6) reported the trim of the outdrive was all the way down where he had set it when he first got onboard the RIB. [Encls (9), (31)]

121. (b)(6) was electrically shocked each of the three times he tried to reach in the water and remove the lifejacket from the propeller. He turned everything off, including the batteries, which he inspected and were visually in good order. [Encl (9)]

122. Shortly thereafter, (b)(6) also reported to the bridge the RIB was dead in the water (DIW). [Encls (8), (28)]

123. (b)(6) turned ENS Mitchell over into a cross-chest carry and towed her back to RIB BILLY HAMPTON. He assessed her injuries as including severe lacerations to her head and face, with a hinged cranium. [Encls (20), (40)]

124. (b)(6) was unable to administer rescue breaths while towing ENS Mitchell because of her jaw injury. [Encl (20)]

125. Meanwhile, the other three survivors, (b)(6), (b)(6), and (b)(6) swam towards each other. [Encls (26), (40)]

126. Once (b)(6) had closed to ten yards away from RIB BILLY HAMPTON, RIB KELLY MILLER arrived on scene and (b)(6) signaled to ask if (b)(6) wanted the assistance of an additional rescue swimmer. (b)(6) signaled back in the affirmative. [Encl (20)]

127. On approach to RIB BILLY HAMPTON, (b)(6), Boat Engineer, tried to yell from his position in RIB KELLY MILLER to the boat crew that the propeller was fouled with a lifejacket. [Encl (41)]

128. The personnel on RIB KELLY MILLER saw blood in the water and heard the call that RIB BILLY HAMPTON was DIW. [Encls (7), (12)]

129. Unaware RIB BILLY HAMPTON was DIW, [(b)(6)] called for and signaled for RIB BILLY HAMPTON to recover him and ENS Mitchell. [Encl (20)]

130. [(b)(6)] directed [(b)(6)] to put the boat in neutral and [(b)(6)] to gear up; [(b)(6)] [(b)(6)] was already donning his SAR equipment. [Encls (7), (32)]

131. [(b)(6)] visually checked the water was clear and began to deploy [(b)(6)], who jumped in the water after only one tap, versus the three required by procedure. [Encl (7)]

132. [(b)(6)] then tried to call [(b)(6)] to his RIB, but [(b)(6)] did not hear him. [Encl (7)]

133. Once [(b)(6)] got closer to RIB BILLY HAMPTON, he requested a line, which [(b)(6)] threw off of the port bow. [Encls (14), (20)]

134. [(b)(6)] assisted in throwing and retrieving the line, which took three attempts to get to ET2 Dekorte. [Encls (14), (29)]

135. [(b)(6)] and [(b)(6)] recovered ENS Mitchell from the water to RIB BILLY HAMPTON. [Encls (8), (20), (40)]

136. At some point, [(b)(6)] recalls directing [(b)(6)] to comfort [(b)(6)] who was saying, "Oh God, Oh God, what did I do?" or words to that effect. [Encls (8), (14)]

137. [(b)(6)] does not recall being directed to do this but does recall observing [(b)(6)] starting to have labored breathing and crying so then [(b)(6)] attempted to comfort him. [Encl (14)]

138. [(b)(6)] tried to distract the midshipmen who had been seated on the port side. [(b)(6)] also tried to comfort [(b)(6)] who he observed hyperventilating, shaking, and with tears in his eyes. [Encl (31)]

139. [(b)(6)] started to swim toward the other three survivors before realizing [(b)(6)] had been deployed to assist them and returned to RIB BILLY HAMPTON. [Encl (20)]

140. [(b)(6)] brought RIB KELLY MILLER alongside RIB BILLY HAMPTON. [Encls (7), (12), (40)]

B. Efforts to treat ENS Mitchell's injuries

141. ENS Mitchell's injuries made her unrecognizable at first. [Encls (7), (8), (20), (24)]

142. After getting ENS Mitchell onboard the RIB, [(b)(6)] began with conducting a patient assessment and found ENS Mitchell had a pulse by placing two fingers on the carotid. Her pulse was rapid and weak. [Encl (20)]

143. [(b)(6)] immediately yelled out that ENS Mitchell was breathing, which was incorrect. He was trying to communicate she was still alive. [Encl (20)]

144. [(b)(6)] told [(b)(6)] they needed to get ENS Mitchell to his RIB, to which [(b)(6)] [(b)(6)] nodded in agreement. [Encl (7)]

145. To transfer ENS Mitchell from RIB BILLY HAMPTON to RIB KELLY MILLER, both crews pull the lines on the RIBs really close together. [Encls (7), (28)]

146. ENS Mitchell was then transferred to RIB KELLY MILLER, with the crew trying to stabilize her head and spine. [Encl (20)]

147. (b)(6) and (b)(6) transferred ENS Mitchell to (b)(6) and (b)(6) [Encls (7), (8), (41)]

148. As soon as (b)(6) and the level A medical kit was in the RIB KELLY MILLER, (b)(6) began transiting back to JASON DUNHAM. [Encls (7), (8), (20)]

149. (b)(6) considered taking more personnel from RIB KELLY MILLER to RIB BILLY HAMPTON but decided against it because RIB BILLY HAMPTON was DIW and still had more personnel to recover. [Encl (8)]

150. After the transfer, (b)(6) stabilized ENS Mitchell's head. [Encls (7), (20)]

151. (b)(6) stated that ENS Mitchell had a faint pulse. [Encl (7)]

152. (b)(6) doused ENS Mitchell's head and facial wounds with saline solution. [Encls (7), (20)]

153. (b)(6) replaced the hinged portion of ENS Mitchell's skull, then wrapped it with the 6" trauma dressing and gauze. [Encls (7), (20)]

154. (b)(6) rapidly assessed ENS Mitchell's limbs and torso, finding bruising on her chest but no hemorrhages or pooling blood. He assessed her head had passed through the propeller. [Encl (20)]

155. (b)(6) reassessed her vitals and found no pulse, no breathing. He started chest compressions and called for a breathing mask. [Encls (7), (20)]

156. (b)(6) tried a jaw thrust to clear the airway before resuming rescue breathing, he was not able to get a good seal. [Encl (20)]

157. (b)(6) was primarily providing medical supplies to (b)(6) [Encl (41)]

158. At approximately 1030, (b)(6) informed the bridge about the severity of the injuries to ENS Mitchell's head and arm; he also stated he thought a helicopter would be needed. [Encls (7), (17)]

159. The CO had a hard time understanding (b)(6) because of wind over the radio, but he heard "first aid" and "CPR". [Encl (21)]

160. The CO yelled down to the boat deck that it was serious, which prompted (b)(6) to tell the crew to be ready at the SLAD for recovery before learning one RIB was DIW such that extra personnel would not be offloaded from RIB KELLY MILLER. [Encl (11)]

161. The helicopter was recovered by JASON DUNHAM at approximately 1039. [Encl (17)]

162. While the helicopter was on final approach, the crew received word there was a medical emergency and MEDEVAC was necessary. [Encl (38)]

163. When JASON DUNHAM radioed to ask RIB KELLY MILLER who the victim was, (b)(6) realized it was ENS Mitchell after looking at her uniform and belt buckle. [Encl (7)]

164. JASON DUNHAM initiated a turn to port to close in on the scene of the incident and because communications with the RIBs were intermittent. [Encls (34), (21)]

165. Via radio, (b)(6) recommended that JASON DUNHAM stop turning to port and instead turn to starboard so the RIB would not have to cross the wake. [Encl (7)]

166. The ship steadied on a course and slowed to 5 kts for recovery. [Encl (34)]

167. (b)(6) requested permission to come alongside at 1031, which was granted. [Encls (7), (37), (40)]

168. (b)(6) JASON DUNHAM Independent Duty Corpsman (IDC), notified the pilot house the helicopter needed to be ready; it was already being prepared. [Encls (35), (38)]

169. (b)(6) requested a litter and initially received a Stokes litter, see figure 5. [Encls (7), (24)]

170. (b)(6) reported he requested the SAR litter via radio on the transit back to JASON DUNHAM. [Encl (12)]

171. Neither (b)(6) nor (b)(6) recall anyone specifically asking for the SAR litter. [Encls (11), (34)]

172. (b)(6) recognized the Stokes litter was not the right litter but the crew tried to make it work until realizing it could not be adequately secured. Then the crew cut the ties to get her out of it. [Encls (7), (13), (40), (41)]

173 (b)(6) was shocked the Stokes litter was lowered first because it does not have flotation attached to it and JASDON DUNHAM had not practiced using it for overboard recoveries before. [Encl (20)]

174. When (b)(6) arrived at the boat deck, the Stokes litter was already in use. The stretcher bearers had also brought the Reeves sleeve. He directed that the Reeves sleeve be lowered to the RIB. [Encl (35)]

175. Within seconds of asking for a different litter, the Reeves sleeve was lowered down to RIB KELLY MILLER. [Encls (7), (44)]

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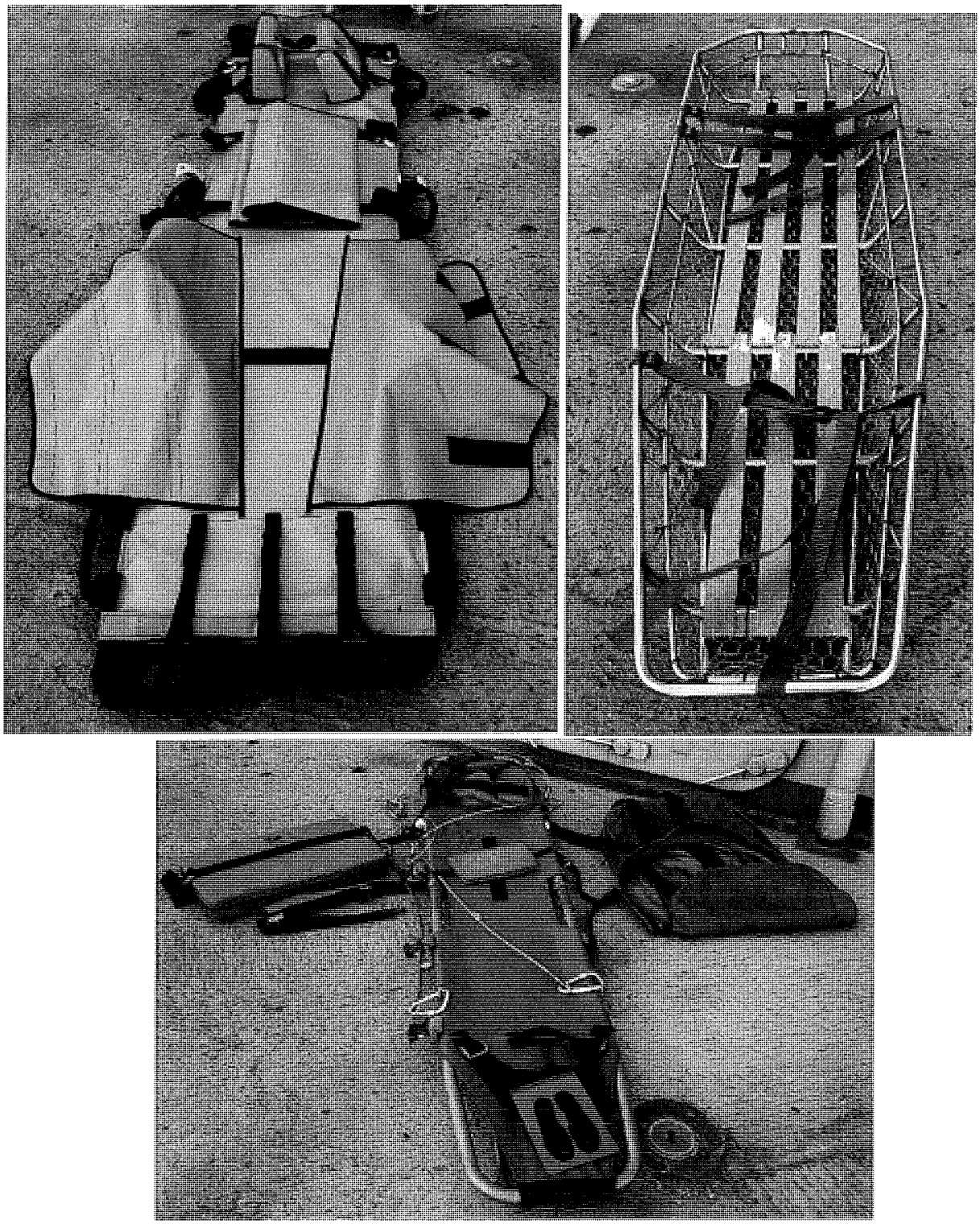

Figure 5, Clockwise from upper left corner: Investigator's photograph of the JASON DUNHAM Reeves sleeve; Investigator's photograph of the JASON DUNHAM Stokes litter; Investigator's photograph of the JASON DUNHAM SAR litter

176. There are diverse opinions about who was in charge of the recovery process. In general, most reported that (b)(6) was in charge of the litter while (b)(6) was in charge of the boat deck. (b)(6) was not present as she was sitting a chief selection board; acting CMC was on scene. [Encls (4), (42), (43)]

177. Damage Control Assistant (DCA) was taking notes and making announcements over the 1MC to dispatch stretcher bearers and the IDC. [Encls (4), (21), (44)]

178. The personnel on the bridge had been discussing how to offload personnel from the RIB so as to raise ENS Mitchel via the SLAD. [Encl (34)]

179. Given the number of personnel and that the helicopter was airborne with only 30 minutes of fuel remaining, recovery of ENS Mitchell via the SLAD was ultimately ruled out. [Encl (34)]

180. The crew rolled ENS Mitchell out of the Stokes litter onto her side and then (b)(6) Boat Engineer (U/I), slipped the Reeves sleeve underneath ENS Mitchell. [Encls (7), (13), (24)]

181. When (b)(6) attempted to resume rescue breathing, (b)(6) yelled down to keep doing chest compressions and to make sure her head was secure. [Encls (7), (20), (35)]

182. (b)(6) heeded (b)(6) advice, not realizing it was (b)(6) at the time, and focused exclusively on chest compressions. [Encls (20), (44)]

183. Someone from the boat deck asked what ENS Mitchell's pulse was, so (b)(6) took her pulse while (b)(6) continued compressions. [Encl (41)]

184. Someone from the boat deck said to use a steadying line, so (b)(6) transferred it from the Stokes litter to the Reeves sleeve. [Encl (7)]

185. (b)(6) continued chest compressions while ENS Mitchell was secured in the Reeves sleeve. [Encls (20), (44)]

186. At 1040, ENS Mitchell was hoisted onboard JASON DUNHAM vertically, head-first to the boat deck. [Encls (7), (20), (37), (44)]

187. ENS Mitchell's head slipped out of the head straps on the Reeves sleeve while she was being hoisted aboard JASON DUNHAM. [Encls (20), (44)]

188. (b)(6) thought the SAR litter should have been rigged up to hoist ENS Mitchell while she lay in a horizontal position versus a vertical one. [Encl (20)]

189. After ENS Mitchell was brought on-board, (b)(6) went to CIC to start coordinating with embassies as necessary for her medical evacuation. [Encl (4)]

190. After "medical emergency" was called over the 1MC, XO went to the bridge. He arrived after ENS Mitchell was back on board. The CO told the XO to stay on the bridge while the CO went to CIC. [Encls (2), (21)]

C. Recovery of the three other personnel and return of RIB BILLY HAMPTON to JASON DUNHAM

191. (b)(6) brought the other three personnel, (b)(6) (b)(6) and (b)(6) to RIB BILLY HAMPTON, where the crew helped pull them aboard. [Encls (8), (9), (16), (25), (28)]

192. In assisting the three personnel, (b)(6) brought them around the blood in the water. [Encls (16), (25)]

193. (b)(6) directed (b)(6) to turn off the batteries and got permission from (b)(6) (b)(6) to redeploy to unfoul the propeller. [Encl (25)]

194. (b)(6) cut the lifejacket off of the propeller and threw it in the RIB. [Encls (9), (25)]

195. (b)(6) did not observe any damage to the propeller or any human hair or tissue in the outdrive. [Encl (25)]

196. (b)(6) did not observe any damage to the outdrive as he trimmed the outdrive back to fully down. [Encl (9)]

197. The engine started and the RIB regained propulsion. [Encls (8), (9), (25), (28)]

198. Personnel aft in the RIB reported getting electrically shocked, so the crew tied a line around (b)(6) (b)(6) for electrical safety and the rest of the crew sat forward in the RIB as they slowly transited back to JASON DUNHAM. [Encls (8), (28)]

D. Ship-board Medical Care

199. ENS Mitchell was transported to main medical onboard JASON DUNHAM by approximately 1043; she arrived at main medical by 1045. [Encls (17), (45)]

200. CPR was discontinued while transporting her and resumed when she got to medical. [Encl (35)]

201. (b)(6) had directed (b)(6) to prepare advanced airway materials. [Encl (35)]

202. (b)(6) observed ENS Mitchell was pale, unresponsive to verbal and painful stimuli, without massive hemorrhages in her extremities, and had an irregular pulse. [Encls (35), (46)]

203. CPR resumed in medical. There were no breath sounds in her buccal/nasal passages. [Encls (35), (46)]

204. (b)(6) performed a cricothyroidotomy on ENS Mitchell and inserted a tube. [Encls (35), (46)]

205. (b)(6) observed the bilateral rise and fall of ENS Mitchell's chest when he performed two rescue breaths. [Encls (35), (46)]

206. The medical team continued chest compressions and rescue breathing while ENS Mitchell was in Main Medical; ENS Mitchell did not breathe on her own. [Encls (35), (46)]

207. (b)(6) observed that ENS Mitchell had a severe depression on the superior aspect of her frontal bone; an approximately 15 cm long and 3 cm wide cut across the crown of her head; ENS Mitchell's right eye was closed and her left eye was not blinking, nor was her eye moving; there was

bloody discharge from ENS Mitchell's left ear; ENS Mitchell's nose was flattened and her septum deviated; ENS Mitchell had an approximately 5.5 cm long by 4 cm wide laceration on the left of her mandible; ENS Mitchell had bruising on her torso and lower back. [Encls (35), (46)]

208. The original bandage had slid off of ENS Mitchell's head, so the medical team rebandaged it with a light compression bandage. [Encls (35), (46)]

209. The medical staff placed an AED on ENS Mitchell, and no shocks were administered while she was in main medical. [Encls (35), (46)]

210. The medical staff performed a needle thoracentesis on ENS Mitchell's right side; there was no audible air and no visible blood from the catheter. [Encl (46)]

211. (b)(6) immediately referred ENS Mitchell to the MEDEVAC and provided his IDC medical bag to (b)(6) for use on the flight. [Encls (21), (35), (46)]

212. (b)(6) went to main medical after he completed his preparations to receive ENS Mitchell onboard while weapons were still being downloaded. He assessed the medical and flight crew preparations as very efficient and swift. [Encl (38)]

213. The helicopter was reported ready to receive ENS Mitchell at approximately 1126. [Encl (17)]

214. ENS Mitchell, attended by (b)(6) and (b)(6) boarded the helicopter at approximately 1129. [Encls (17), (35)]

E. Medical care in-flight and in the hospital

215. Once onboard Venom 506, the SH-60 helicopter, (b)(6) and (b)(6) alternated in performing CPR on ENS Mitchell. [Encls (38), (45), (46)]

216. (b)(6) contacted the Senior Medical Officer on the USS IWO JIMA (LHD 7) who advised administering epinephrine via an intravenous line. (b)(6) was not able to communicate that to (b)(6) [Encl (35)]

217. The helicopter departed JASON DUNHAM for the military hospital in Safaga, Egypt at approximately 1133. [Encl (17)]

218. The helicopter was originally going to take ENS Mitchell to Safaga, Egypt, which was 55 nautical miles from JASON DUNHAM. After takeoff, the helicopter was revectored to the military hospital in Aqaba, Jordan, which was 100 nautical miles from JASON DUNHAM. [Encl (21)]

219. While in flight, the AED delivered one shock to ENS Mitchell before calling for the continuation of CPR. [Encls (38), (46)]

220. The shock briefly restored ENS Mitchell's pulse, which was faint. [Encl (38)]

221. (b)(6) was unable to place an intravenous (IV) line in ENS Mitchell in flight. [Encls (38), (46)]

222. On observing the dressing of ENS Mitchell's head wound had completely soaked through, (b)(6) (b)(6) and (b)(6) cut the bandage off and replaced it. [Encl (38)]

223. (b)(6) and (b)(6) accompanied ENS Mitchell to the emergency room at Prince Hashem Bin Abdullah II hospital in Acaba, Jordan, where they landed at approximately 1230. [Encls (38), (46), (47)]

224. ENS Mitchell was taken to the nearest trauma room, and additional medical equipment was used to check her pulse. [Encls (38), (47)]

225. The trauma team's initial assessment of ENS Mitchell was no pulse and no breathing sounds. [Encl (47)]

226. The hospital's CPR team performed two cycles of CPR on ENS Mitchell and found no response. [Encl (47)]

227. The trauma team observed that ENS Mitchell had fixed, dilated pupils, and a depressed skull fracture at the right frontal area. [Encl (47)]

228. The trauma team also examined ENS Mitchell's head injury, finding an open skull fracture and exposed brain tissue. [Encl (47)]

229. The CPR team stopped CPR. [Encl (47)]

230. ENS Mitchell was pronounced deceased at 1245 on 8 July 2018. [Encls (46), (47)]

231. ENS Mitchell's remains were escorted to IWO JIMA, who turned her remains over to Mortuary Affairs for transportation back to the United States at approximately 1000 on 9 July 2018. [Encl (46)]

F. Recovery of RIBs and Helicopter

232. RIB BILLY HAMPTON broke away again in order to get 1000 yards off of the starboard quarter of JASON DUNHAM for the helicopter to be launched. [Encls (7), (20)]

233. RIB KELLY MILLER also had to wait to be recovered until the helicopter took off. [Encl (28)]

234. RIB KELLY MILLER was recovered before RIB BILLY HAMPTON as its crew had gone in the water. [Encl (7)]

235. RIB KELLY MILLER was recovered at approximately 1139. [Encl (17)]

236. RIB BILLY HAMPTON was recovered at approximately 1147. [Encl (17)]

237. The helicopter left the military hospital in Aqaba at approximately 1348 and was recovered by JASON DUNHAM at approximately 1525. [Encl (17)]

G. Post-incident inspection of RIB BILLY HAMPTON

238. (b)(6) Chief Engineering Officer, personally inspected RIB BILLY HAMPTON on 9 July 2018. [Encl (48)]

239. (b)(6) observed damage to the propeller of RIB BILLY HAMPTON. Specifically, he observed a gouge on the leading edge of one of the propeller blades and unknown fibers caught in the gouge, see figures 6 and 7. [Encl (48)]

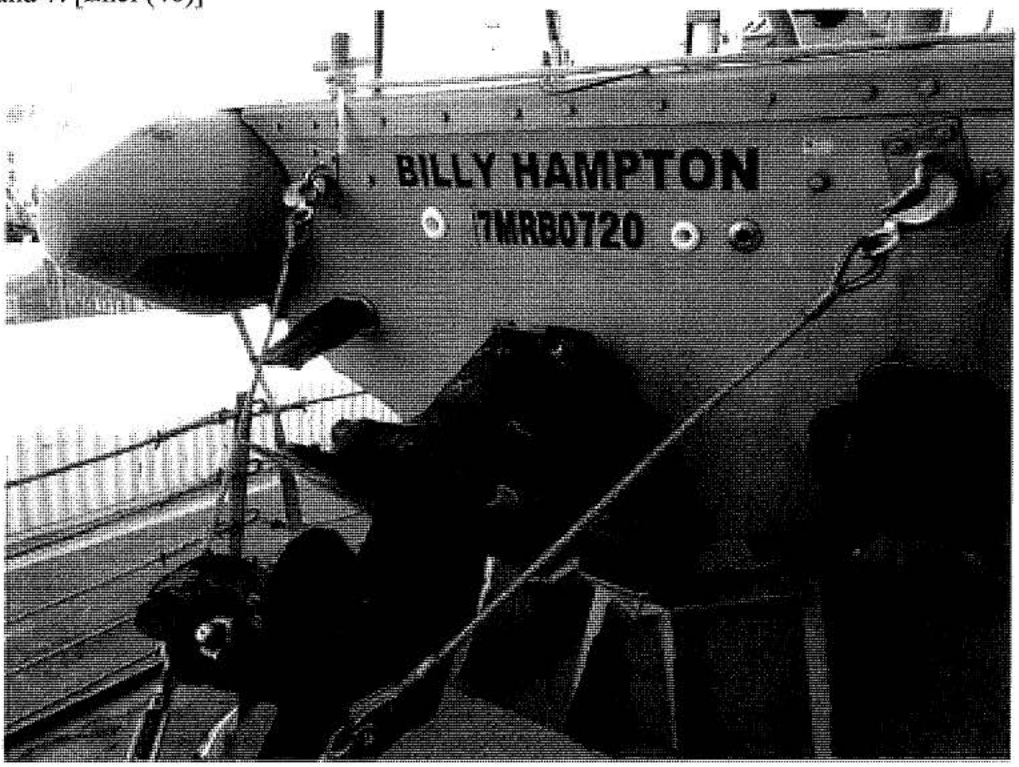

Figure 6, Investigator's photograph of the RIB BILLY HAMPTON

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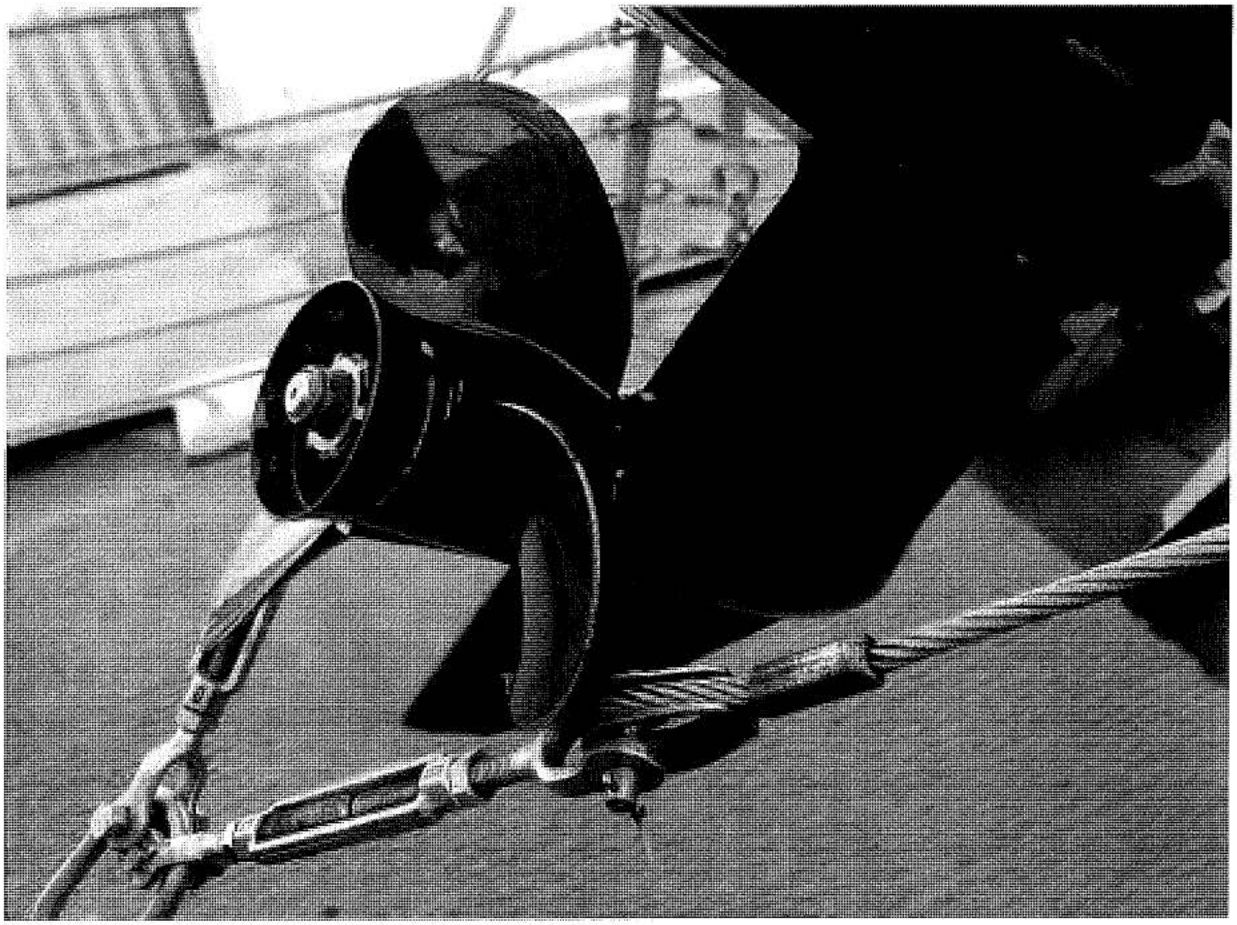

Figure 7, Investigator's photograph of the propeller from RIB BILLY HAMPTON

240. (b)(6) actions to throw ENS Mitchell's lifejacket into the RIB after unfouling the propeller preserved it for later review, see figure 8. [Encls (25), (45)]

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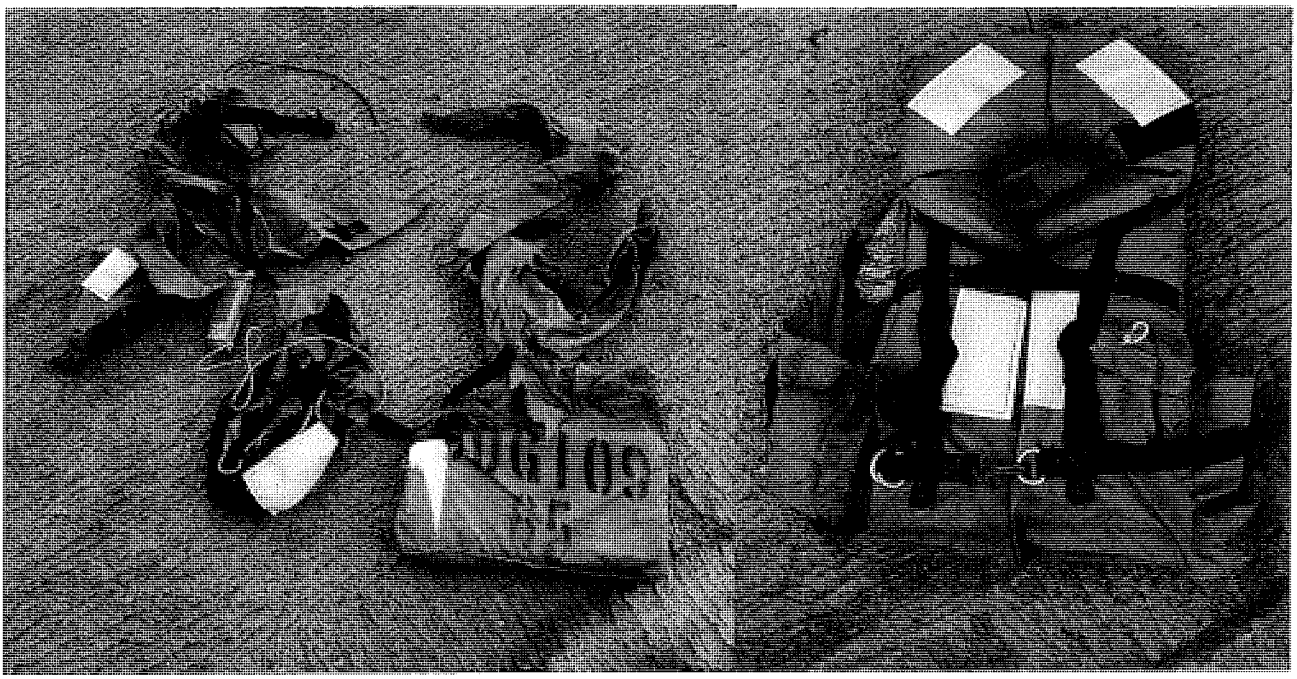

Figure 8, Side by side comparison of ENS Mitchell's recovered lifejacket and an intact lifejacket (KAPOK)

IV. Training, qualifications, and technical proficiency of JASON DUNHAM personnel

241. Multiple crew members reported there is a culture of training, particularly to real-world standards. [Encls (4), (42), (5), (48), (2)]

242. The XO is overall in charge of training. The Training Officer works for the Operations Officer. [Encl (4)]

243. Although the Operations Officer owns planning, the responsibility to brief an evolution belongs to whomever owns the evolution. [Encl (4)]

244. Typically, in preparation for operations evolutions, personnel meet at least 24 hours in advance and brief it, usually immediately after the Operations Intel Brief. [Encls (4), (21), (49)]

245. After an evolution gets scheduled on the ship's calendar, it is up to the Department Head to brief and prepare their departmental personnel. [Encl (2)]

246. The Operations Officer noted that the usual pattern and timeline for planning and briefing is not followed in the case of small boat operations, but did not know why. [Encl (4)]

247. The culture of planning applies to all evolutions except what some see as more routine: flight operations and small boat operations. [Encl (49)]

248. The CO perceives Plan Brief Execute Debrief (PBED) as being applied to all small boat operations. [Encl (21)]

249. For at least one specific type of training involving small boats, Fast Intruder Attack Craft (FIAC), the evolution was pre-briefed. [Encl (5)]

250. There is no local training on how to handle a man overboard scenario where personnel fall out of a RIB. The man overboard training focuses on scenarios where personnel exit from JASON DUNHAM. [Encls (7), (41)]

251. The Boat Crews on 8 July 2018 had attained the following relevant qualifications. Some of the records diverged by a day or two, based on dates entered into records systems:

RIB KELLY MILLER		
Crew Member	**Position**	**Date**
(b)(6)	7M RIB Boat Officer	1 June 2018
	Bow Hook and Stern Hook	15 June 2018
	7M RIB SAR Swimmer	4 May 2018
	7M RIB Boat Engineer	17 September 2016
	7M RIB Coxswain	10 July 2017
RIB BILLY HAMPTON		
Crew Member	**Position**	**Date**
ENS Mitchell	7M RIB Boat Officer	2 June 2018
ENS Mitchell	Bow Hook and Stern Hook	15 June 2018
(b)(6)	7M RIB SAR Swimmer	20 August 2016
	7M RIB Boat Engineer	11 April 2018
	7M RIB Coxswain	1 October 2016

[Encls (50), (51), (52), (53), (54)]

A. SAR Training

252. (b)(6), as the SAR officer, had not trained on how to raise a Reeves sleeve from a RIB. [Encls (7), (55)]

253. The ATG inspection only includes using the J Bar Davit with the SAR litter, and no others. [Encls (7), (20)]

254. There is no training specific to recovering a man overboard after an ejection from a RIB; the SAR swimmers do not see this as meaningfully different from any other man overboard scenario. [Encls (7), (9), (20)]

255. There is no training, ATG or otherwise, that covers recovering a patient from a RIB via a litter. [Encl (20)]

256. (b)(6) qualified as a SAR swimmer on 4 May 2018. [Encl (25)]

B. Coxswains

i. (b)(6)

257. (b)(6) has been in the Navy for 18 years and qualified as a coxswain for 15 years. [Encl (9)]

258. (b)(6) earned his qualification by training under other experienced coxswains by completing the Personal Qualification Standards (PQS), as specified in NAVEDTRA 43152-L. [Encl (9)]

259. (b)(6) was trained the RIB can travel at close to 30 kts. [Encl (36)]

260. In deciding how quickly the RIB can be operated, (b)(6) considers the weather conditions; number, weight, and placement of personnel on board; sea state; and the mission. [Encl (36)]

261. (b)(6) believes speed impacts turn execution in that it makes the engine work harder. He did not offer any other relationships between speed and turn execution. [Encl (36)]

262. (b)(6) executes a donut by turning the wheel all the way in the direction he wants to turn. He does not adjust the throttle, although he maintains positive control of the throttle in the event he needs to adjust it. [Encl (36)]

263. (b)(6) learned how to do donuts when he was first trained as a coxswain. He was taught the maneuver potentially useful in a FIAC scenario. [Encl (36)]

264. (b)(6) believes someone is only at risk of ejection by executing a donut or hard turn if the sea state is rough. [Encl (36)]

265. (b)(6) believes it is safer for a passenger to sit on the sponson if the seats, such as those in front of the helm, are already taken as he believes that is more stable than standing. [Encl (36)]

266. (b)(6) learned about where and how to position people, including that sitting is more stable than standing, when he was getting qualified as a coxswain. [Encl (36)]

267. (b)(6) has inexperienced personnel onboard, he makes sure their lifejackets fit properly and they are hanging onto the RIB. [Encl (36)]

268. (b)(6) is not aware of how to use a centerline lifeline in the RIB, nor has he ever seen one rigged up. [Encl (36)]

269. (b)(6) is not intimately familiar with the BIB (Boat Information Book) on 7M RIBs, reference (b). [Encl (36)]

270. (b)(6) believes he has read the local JASON DUNHAM Boat Bill, reference (c) one time. [Encl (36)]

ii. (b)(6)

271. (b)(6) has been a qualified coxswain for 16 years and has been to coxswain school for 7M RIBs and Level II training. [Encl (11)]

272. (b)(6) was an instructor on small boat operations at Coastal Riverine Group TWO. [Encl (11)]

273. (b)(6) is one of the boat deck safety officers on board JASON DUNHAM. [Encl (11)]

274. (b)(6) would not call donuts "maneuvers." Instead, he stated that those are just what people do when they want to drive quickly and have fun. [Encl (11)]

275. In order to execute a hard turn, (b)(6) would throttle down, particularly if there are a lot of inexperienced people on board. [Encl (11)]

276. (b)(6) would call a slip turn a "chine," which is when inside edge of the boat digs into the water before ultimately pushing the outside edge into the water. Boats with square hulls are more like to do this. [Encl (11)]

277. (b)(6) believes that RIB BILLY HAMPTON "chined" here because personnel fell off of the starboard side during a hard turn to port. [Encl (11)]

278. In (b)(6) experience, a boat is more likely to chine the more hard turns you do in succession. [Encl (11)]

279. (b)(6) would prefer for his coxswains to go to the 7M RIB school. [Encl (11)]

280. (b)(6) was the coxswain for the JASON DUNHAM to complete SAR certification, so he had no concerns about his abilities without completing the school. [Encl (11)]

281. (b)(6) would like to see more time allowed to prepare for planned RIB evolutions and for there to be time to conduct a safety brief with the coxswains ahead of time. [Encl (11)]

282. (b)(6) would like to see guidance mandating safety briefs whenever 60 percent or more of all passengers on board the RIB are inexperienced or unqualified. [Encl (11)]

iii. (b)(6)

283. (b)(6) has attended multiple coxswain schools, both for 7M RIBs and Level II training. [Encl (12)]

284. While in school, (b)(6) was not given rules for when hard turns and donuts can be executed. [Encl (12)]

285. He was taught to give an audible warning for passengers ahead of executing a hard turn. [Encl (12)]

286. (b)(6) did not have a guess as to what caused the incident on 8 July 2018 with RIB BILLY HAMPTON. He believes even if they executed 180 degrees of a turn, the RIB would still not catch its own wake. [Encl (12)]

287. (b)(6) reported he would never execute a tight turn at full throttle because it is unsafe and risks losing control over the RIB. [Encl (12)]

iv. Comparison of formal training to PQS

288. Formal training is assessed to be far more in-depth than the PQS method. [Encls (56), (57)]

289. Experienced coxswains who qualified via PQS but then went to serve as instructors at the school have reflected that the PQS method did not cover a lot of topics and details the school covers. [Encls (56), (57)]

290. Completing school does not excuse a Sailor from completing the unit's PQS to serve as a coxswain. [Encl (56)]

291. Instructors at the Center for Surface Combat Systems (CSCS) in operating small boats assess the PQS method does not teach all of the Navy Standard Technical Manual and Boat Information Book (reference (BIB)). [Encl (56)]

292. The same instructors teach passengers should not sit on the sponson and they should crouch or stand as far astern as possible while holding onto inboard lifelines and fixed handles. [Encls (56), (57)]

293. The instructors would never execute a turn with full throttle and full rudder in a 7M RIB because it risks "tripping" where the bow of the vessel dips into the water on the inside edge of the turn and the propeller then lifts out of the water. The boat will feel like it's thudding when it comes back into the water. [Encl (56)]

294. The instructors specifically teach their students "tripping" is a risk and teach them how to avoid tripping. [Encl (56)]

295. The BIB describes how to sit on the sponson if someone is going to sit on a sponson, but CSCS teaches that passengers should crouch or stand while holding onto handles and lines in the RIB. [Encl (57)]

296. Sitting on the sponson is like sitting on a trampoline in that it amplifies any bumps from waves and can bounce a passenger out of his or her seat. [Encl (57)]

297. CSCS Instructors also teach students to rig up the centerline lifeline and to position personnel in the seat on the front of the console before considering alternative locations. [Encl (57)]

298. One instructor asserted he would never execute a pivot turn with 10 passengers on board, especially if the passengers were inexperienced. [Encl (57)]

299. Ejections are relatively infrequent. Personnel interviewed had little to no experience with them. [Encls (11), (12), (56), (57)]

300. Each destroyer is required to have at least two coxswains on board who have attended the basic 7M RIB coxswain school. [Encl (58)]

301. The CSCS course (K-062-0625) is offered four times a year at the Little Creek, Norfolk, Virginia location, with similar frequency at the other locations. The courses usually have two to four open seats. It is a two-week-long course consisting of classroom and in water live training. [Encls (56), (57), (59), (60)]

C. Small Boat Officer training

302. (b)(6) as the recently reported Operations Officer, introduced a renewed interest in getting junior officers qualified as small Boat Officers. [Encl (8)]

303. Only half of the fourteen junior officers on board JASON DUNHAM are qualified Boat Officers. [Encl (51)]

304. JASON DUNHAM does not have a lot of time to do small boat operations, so whenever they have a long underway, they try to schedule small boat operations and get junior officers qualified as Boat Officers. [Encl (5)]

305. There is no official Navy or Surface- wide training for Boat Officers, so the training must be done "On the Job." [Encl (2)]

306. Small Boat Officer training focuses on getting the junior officers in the RIBs, learning what the RIBs can do, and learning about the role of each member of the boat crew. [Encl (4)]

307. (b)(6) who is the Training Officer as well as the Midshipmen Training Officer, did not receive any specific guidance more specific than reference (d) on how to conduct the two phases of midshipmen that joined JASON DUNHAM. [Encl (49)]

308. ENS Mitchell had previously been on a small boat with (b)(6) in seas with 6-8 foot swells. She did not appear to have a hard time holding on. [Encl (9)]

V. Command Climate

309. Crew perceives XO and CO as creating a safety-oriented environment. [Encl (4), (5), (43), (48)]

310. The CO's vision of excellence is generally understood by the crew although some members believe it is not taken seriously by everyone else on board. [Encls (4), (5)]

311. The CO is very active on the ship and is rarely in his stateroom. The XO is very focused on the POD and training. [Encl (42)]

Opinions

1. The ejection of four personnel from RIB BILLY HAMPTON was avoidable. There are three root causes and three areas of concern.

2. The root causes of the ejection of four people from RIB BILLY HAMPTON are:

a. JASON DUNHAM Coxswain of RIB BILLY HAMPTON neglected to safely operate the RIB with 11 passengers in accordance with references (b), (c) and (e)- (j).

b. JASON DUNHAM was complacent with respect to small boat operations and failed to apply Planning, Briefing, Executing and Debriefing (PBED) when combined with a training event.

c. The written guidance to coxswains inadequately addresses safe operations of RIBs and the PQS manual fails to require knowledge of known hazards as a requirement for Coxswains and Boat Officers.

3. The contributing factors were:

a. JASON DUNHAM last minute scheduling.

b. JASON DUNHAM lack of forceful backup.

c. JASON DUNHAM task saturation.

4. The other areas of concern are:

a. JASON DUNHAM (b)(6) was TAD to Millington, TN to participate in a selection board.

b. JASON DUNHAM preservation of potential visual evidence did not exist due to improper operation of OSS.

c. There is no Surface Force Readiness Manual (SFRM) training for recovering a patient from a RIB via litter.

I. Root Cause 1: Actions by the Coxswain

5. Safe RIB operations were not executed by the JASON DUNHAM Coxswain, (b)(6) of RIB BILLY HAMPTON on 8 July 2018. This was not a result adverse conditions; sea state was 1-2, winds less than 7 knots, visibility was unrestricted. (b)(6) failed to safely operate the RIB in accordance with references (b), (c) and (e)- (j). [FFs (38, 40, 46, 75-98)]

6. Hazardous maneuver. As a result of (b)(6) executing a full throttle, full turn to port, the RIB BILLY HAMPTON experienced a hazardous maneuvering event called "tripping" wherein the stern is temporarily airborne. Figures 8 and 9 below illustrate this effect. As a result of the coxswain causing the RIB to trip, four personnel were ejected at the time when the bottom of the RIB hit the water. Of note, the SAR swimmer self-ejected, bringing the total number of personnel in the water to five. The last person to be ejected was the Boat Officer, ENS Mitchell, a result of her forward position on the starboard bow and retaining a longer grip on the inboard lifeline. This caused her to pass directly under the RIB and being struck on the head by the outdrive, which inflicted severe head trauma and caused her death later that day. [FFs (78-87, 90-97, 293-294, 208)]

Figure 9, showing a 7M RIB executing a hard turn, source Wikimedia Commons

OUTDRIVE "Tripping" Illustration

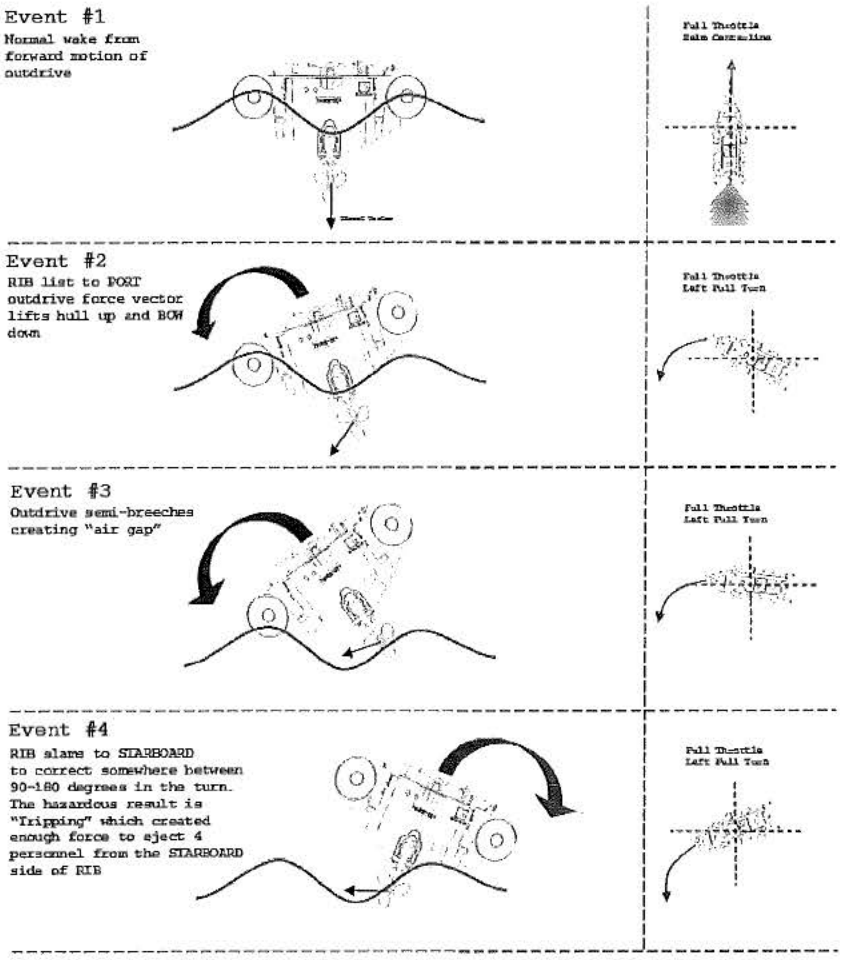

Figure 10, Investigating Officer's illustration of tripping

7. Failure to evaluate risk. Although the RIB may have the performance capability to execute such a maneuver, a hard turn puts the passengers at significant risk. (b)(6) failed to properly evaluate this risk. Each member of the four-person boat crew had qualified via PQS, however, ENS Mitchell was the least experienced. In fact, this was ENS Mitchell's first RIB ride as a Boat Officer since being qualified. The remaining seven RIB riders were novices as Midshipmen and personnel under instruction. [FF (27-31, 38, 40, 46-62, 75-98)]

8. Inferred permission. (b)(6) decision to execute the hazardous maneuver was not based on any specific guidance for this training event. He recounted discussing with ENS Mitchell the actual Boat Officer training to be conducted and they both wanted to "have some fun," which (b)(6) interpreted as implied permission to execute high-speed maneuvers. The accuracy of his recollection cannot be assessed. [FF (29, 37-40, 48, 274)]

9. The Coxswain is responsible for the safe operations of the RIB, while the Boat Officer is overall responsible for the RIB. (b)(6) has 18 years of service and PQS qualified as a coxswain for 15

years. He has never attended the CSCS Coxswain school or any other formal training on operating 7M RIBs. Although, individuals are not required to attend, destroyers are only required to have two graduates of the 7M RIB Coxswain school in accordance with FLTMPS (as of 2004). However, his experience should have been enough to preclude him from making such a high risk maneuver. (b)(6) was overconfident in his abilities on 8 July 2018. Outside of an operational requirement, (b)(6) should have never attempted a hard turn with full throttle and full rudder. In this instance, (b)(6) should have taken into account the weight of the RIB with 11 people on board, their positions seated on the sponson, the number of personnel seated forward in the RIB, the inexperience of the personal on board, and his experience with operating 7M RIBs to appreciate the risk; then he should have taken steps to mitigate that risk. [FF (257-270, 280, 288-301)]

II. Root Cause 2: Complacency and failure to apply PBED to training involving RIBs

10. While Planning, Briefing, Executing and Debriefing (PBED) is normally implemented onboard JASON DUNHAM in accordance with references (i) and (j) to conduct training and special evolutions, it was not employed on 8 July 2018 for Boat Officer Training and Midshipmen familiarization. [FF (1-36, 241-249)]

11. JASON DUNHAM CO generally sets a standard of excellence and leads his team to effectively accomplish the mission. The crew perceives operations as being safety oriented. CO and XO execute the roles to be expected of a CO and XO relationship in conducting operations. While deployed conducting Fifth Fleet operations, JASON DUNHAM makes training a priority to achieve the CO's vision of excellence. XO actively leads the training efforts and employs his training team leaders to execute the process. [FF (6, 116, 160, 164, 190, 309-311)]

12. Failure to plan and brief. Small boat operations for Boat Officer Training and Midshipmen familiarization was considered normal/routine operations and did not receive the disciplined process given to other training team events. Small boat operations may be considered normal/routine for the four qualified crew members, however, since the event included 7 novice RIB riders the event was higher risk. By properly planning and briefing, leadership could have identified risks and provided guidance on the purpose of the training. This could have extinguished any ideas "joy riding", "showing off", or taking the RIBs to their limits was permissible. [FF (1-36, 241-251)]

13. Blind spot for small boat operations. Potential hazards to personnel inherent in small boat operations are also increased with the infrequency of the operation. Small boat operations had only been conducted two times this deployment raising the concern of whether the operation was truly routine. The Operations Officer, recognizes the importance of the PBED process and the responsibility for these briefs falls to the department executing the evolution. However, the Operations Officer, along with the XO and CO, failed to see one of his own divisions was not following that standard. In fact, the CO believes that PBED is being implemented for small boat operations training. While some crew see small boat operations as so routine a brief is not required, others believe it should be applied to small boat operations when it is training but are not verifying their perceptions. By conducting the more disciplined PBED process the incident may have been prevented. [FF (1-36, 241-251)]

III. Root Cause 3: Inadequate guidance on RIB operations and inadequacy of PQS standard

14. The operation of the RIB (Root Cause 1) together with the positioning of the crew and passengers within RIB BILLY HAMPTON and the setup of the RIB contributed to the incident on 8 July 2018. Although the coxswain's poor judgment and operator error in driving the RIB were not in accordance with the prudent operations demanded by references (b), (c) and (e)- (j), the currently available references

and guidance do not provide adequate training on safe operations. Additionally, the qualified members of the boat crew were unfamiliar with the centerline lifeline and all believed the safest position on a RIB was to be seated on the sponson. The lack of familiarity and prevalence of the practice to sit on the sponson suggests there is a training deficiency not only on JASON DUNHAM but potentially across the enterprise. [FF (37-40, 46-62, 75-98, 257-301)]

15. Unfamiliarity with all 7M RIB safety gear and poor positioning of personnel onboard the RIB. Chapters 3 through 18 of reference (b) delineate the rails and lifelines are provided for the safety of the crew and embarked personnel. All JASON DUNHAM personnel interviewed who have participated in small boat operations on JASON DUNHAM were not using all of the gear described in reference (b). All interviewed personnel believed that the proper way to ride in a RIB is to sit on the sponson while holding the inboard lifeline, which leaves the seat on the front of the helm and the centerline lifeline, if rigged, untouched. The passengers of RIB BILLY HAMPTON on 8 July 2018, who were all U/I or novice RIB riders, were instructed by JASON DUNHAM coxswain(s) and boat officer(s) during this ride or on previous ride(s). ENS Mitchell and (b)(6) might not have been properly instructed on safe RIB riding either. The only local guidance, reference (c), expressly states passengers are to remain seated when the RIB is transiting. Furthermore, (b)(6) did not have the benefit of attending 7M RIB coxswain school. There appears to be no knowledge of the centerline lifeline or reference to its use onboard JASON DUNHAM. The CSCS instructors teach the sponson functions like a trampoline and therefore personnel should crouch or stand onboard a RIB, using the centerline lifeline in addition to the inboard lifelines. Had personnel been properly instructed on how to ride the RIB and used the additional safety gear, all four individuals might not have been ejected when (b)(6) executed a hard turn to port and the RIB tripped. [FF (75-98, 292-297)]

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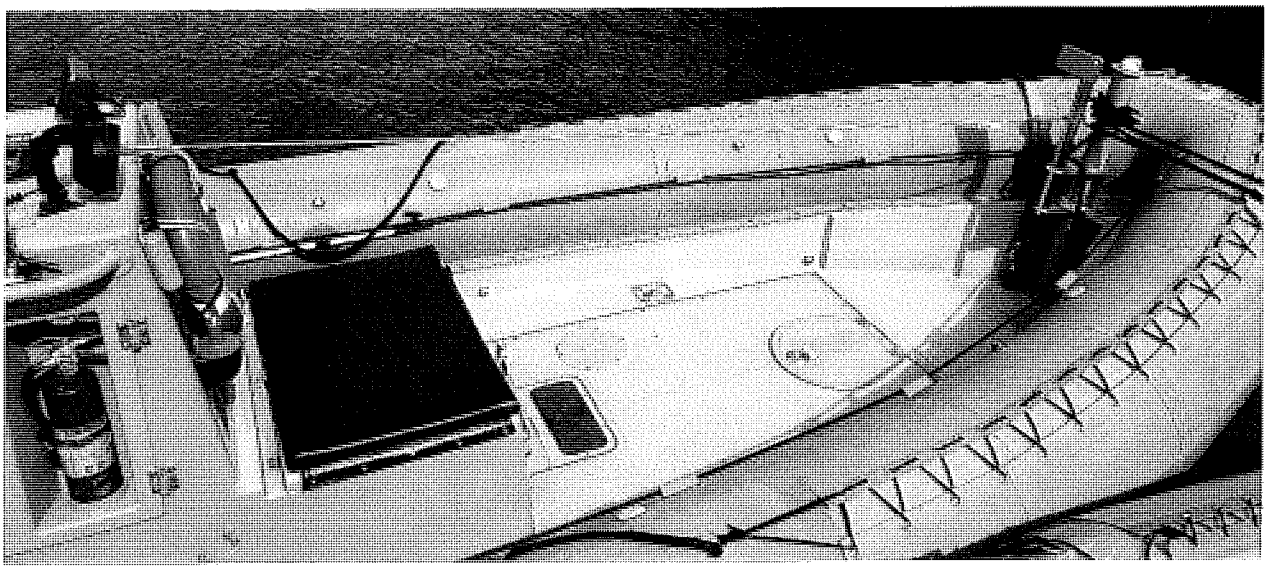

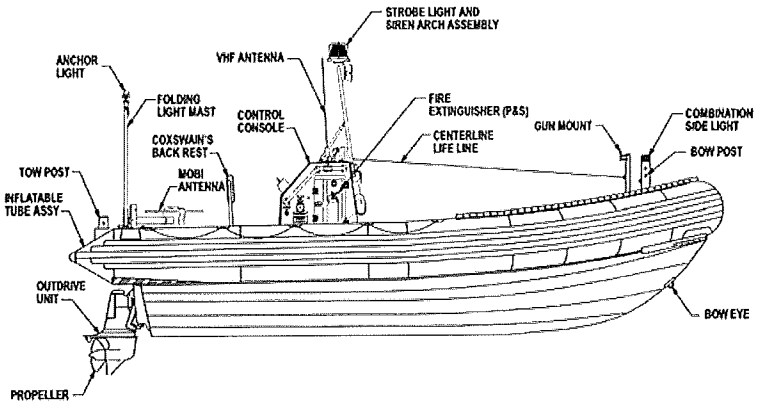

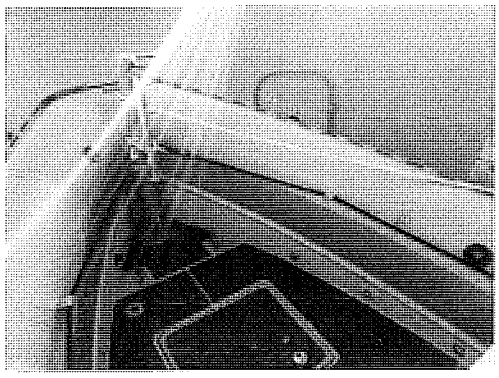

Figure 11, Clockwise from top, 7M RIB with centerline lifeline rigged; Investigator's photograph of inboard lifeline on RIB BILLY HAMPTON; 7M RIB diagram sourced from Reference (b).

16. Training deficiency. The CSCS 7M RIB Coxswain class (COI K-062-0625) teaches safe operations of RIBs including: how to detect and avoid tripping, safety considerations for executing maneuvers, how to safely position passengers on the RIB, how passengers should stand or crouch onboard the RIB, and how to use the centerline lifeline. The inconsistency of this training and knowledge on JASON DUNHAM and the Fleet is a concern. [FF (251, 257-301)]

17. PQS deficiency. The Final Qualification PQS for 7M RIB Coxswains (Watchstation 302) and Boat Officers (Watchstation 305) located in reference (NAVEDTRA 43152-L) fails to require RIB fundamentals 102. The section 102.21 requires knowledge of known hazards like tripping, as well as, the proper execution of hard turns like pivot turns. The Final Qualification PQS does not require boat officers and coxswains to be familiar with the entire guide. Instead, the Final Qualification PQS is a selection of elements from throughout the guide. In selecting which elements were critical for qualification, familiarity with the fundamentals was omitted. This gap in knowledge is a concern. [FF (257-301)]

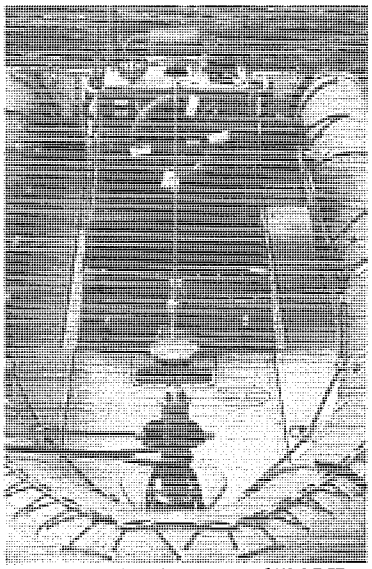

Figure 12, Another view of 7M RIB with centerline lifeline rigged.

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18. Inadequacy of guidance. Reference (b) does not explicitly state that standing or crouching is preferred, instead implying that sitting on the sponson is a less preferred position for passengers. Clear guidance is a concern [FF (75-98, 292-297)]

19. Knowledge gap between JASON DUNHAM Coxswains. (b)(6) and (b)(6) both graduates of CSCS 7M RIB Coxswain, claimed they would have never executed a full throttle, full turn because it was a hazardous maneuver. However, (b)(6) did not object to his coxswains having passengers seated on the sponson and passengers of (b)(6) RIB were seated on the sponson. Additionally, neither RIB rigged the centerline lifeline. These discrepancies between CSCS training and Fleet practice may dovetail with the above concerns about the consistency of the guidance on RIB operation. Addressing these training deficiencies may prevent future incidents. [FF (251, 257-301)]

IV. Contributing Factors

20. Last minute scheduling. The small boat operations for Boat Officer Training was planned for 6 July and cancelled due to weather. It was subsequently added on to the 8 July 2018 Plan of the Day the evening of 7 July due to the favorable weather forecast. The entire Deck Division was required to conduct dual RIB operations and Flight Quarters, of which many had just finished the 00-07 watch. The compressed notice degraded organizing the event, preventing supervisors from following the PBED process and issuing guidance or training expectations. The last-minute nature was exacerbated by the task saturation of the Deck Division on 8 July 2018, when all hands were engaged in either VBSS, small boat operations, manning the boat deck, or flight operations. [FF (1-36, 241-249)]

21. Failure of forceful backup. The only supervisor, (b)(6) to recognize the unsafe maneuvering of RIB BILLY HAMPTON prior to the incident, attributed his lack of forceful backup to not having enough time or the tools on hand to give guidance to his coxswain. (b)(6) later recognized he should have contacted RIB BILLY HAMPTON via a radio to stop the unsafe maneuvering. Had he provided forceful backup, he may have been able to intervene to avert this tragedy. Similarly, other members of the crew observed PBED was not applied to small boat training operations whereas it is consistently applied to other evolutions and training events. Those members could have exhibited a questioning attitude to learn about the process differentiation and potentially limited the risk on 8 July 2018. [FF (1-36, 46-50)]

22. Task saturation. During the time frame between 0800-1100 the following events were scheduled: DCTT exercise, VBSS exercise, Flight Operations, Re-enlistment, Boat Officer Training and Midshipmen RIB familiarization. The complexity of executing these events simultaneously was not recognized by JASON DUNHAM. Since the nature of these events is heavily dependent on Deck Division personnel to perform, they bore the brunt of the risk. Providing event supervisors with decision space to prioritize and plan events (implement PBED) may have prevented the incident. [FF (1-45, 105)]

V. Areas of Concern

23. PERS prioritization of selection-board participation over JASON DUNHAM operational needs. Having the JASON DUNHAM CMC off of the ship for administrative requirements impaired JASON DUNHAM readiness and mission accomplishment. As member of the TRIAD, CMC provides vital forceful backup to the CO and XO in the day-to-day execution of the POD and administration of the ship while underway. The experience and training of a CMC cannot be understated; the position is invaluable to a deployed ship. The JASON DUNHAM was busy on 8 July 2018 and the response to render aid to ENS Mitchell involved a significant portion of the crew. I am unable to assess whether or not the presence of the CMC would have prevented the incident. Perhaps she would have provided the CO and

XO with some perspective on the number of evolutions the Deck Division was tasked with concurrently. Maybe her presence would have helped bring order to the boat deck while recovering ENS Mitchell from the RIB. These are just speculative examples of the impact her presence could have had. The CMC would have certainly been invaluable in the aftermath of the tragedy. Ultimately, the prioritization of administrative needs over operational obligations is an area of concern. [FF (176)]

24. JASON DUNHAM did not have any recorded video evidence of the maneuvering incident. There is no requirement to record boat operations. Ship's Nautical or Otherwise Photographic Intelligence Exploitation (SNOOPIE) team was not deployed because the training did not require video collection. In CIC, it is standard practice for the manned OSS watch station to monitor surface activity. Whether the OSS observed the incident cannot be verified because no video recordings exist due to improper equipment setup. A video recording of the incident may have been able to further confirm the hazardous maneuver identified in Root Cause 1, but would not have prevented the incident. [FF (104)]

25. Confusion over proper litter use. Overall, the response of JASON DUNHAM personnel to the medical emergency was extraordinary. However, the personnel on the boat deck struggled to send the correct litter down to RIB BILLY HAMPTON. This could be caused by a potential gap in training because no one interviewed had ever been trained to or evaluated on hoisting an injured person from a RIB despite being fully qualified and certified. Personnel on the boat deck considered two options for recovering ENS Mitchell, but not a third option. [FF (169-176, 180, 184, 188)]

a. The first option JASON DUNHAM considered was raising the RIB via the SLAD and keeping ENS Mitchell in the RIB. This option was rejected because with 11 people on board the RIB, it exceeded the maximum capacity of the SLAD. Debarking the extra passengers to reduce the weight would have taken too long and ENS Mitchell was being treated forward in the RIB, which is also where personnel would normally exit via the pilot's ladder. [FF (169-176, 180, 184, 188)]

b. The second option, which JASON DUNHAM ultimately chose was to raise ENS Mitchell via a hand-tended litter. This option was chosen because it provided the fastest way to get ENS Mitchell onboard for medical treatment. The first litter sent down to the RIB was the Stokes litter (see figure below). After further evaluation the second litter sent down was the Reeves Sleeve (see figure below) in order to provide better support of the head. [FF (169-176, 180, 184, 188)]

c. The third option never considered by the boat deck but requested by the RIB crew, was to recover by the SAR litter (see figure 5). JASON DUNHAM was certified with SAR litter, but had only been trained to do so by using the J-Bar Davit. Per reference (k), this is the only option of the three that provides a horizontal versus vertical extraction. This is also the type of litter that the RIB boat crew requested. No one on JASON DUNHAM recalls hearing the request specifically for a SAR litter. Training on the SAR litter would increase familiarity and make personnel more likely to consider it as an option should they face a similar situation again. [FF (169-176, 180, 184, 188)]

26. ENS Mitchell was recovered in the most expeditious manner in order to provide onboard medical treatment. An assessment of the choice of extraction was not made. Identifying a potential medical training gap is an area of concern. [FF (99-198)]

VI. Non-contributing Factors

27. Because of the severity of ENS Mitchell's injuries, I do not assess the brief delay created by the initial attempt at using the Stokes litter as a contributing factor to ENS Mitchell's death. [FF (123-240)]

28. Because of the severity of ENS Mitchell's injuries, I do not assess her head slipping out of the head straps on the Reeves sleeve as a contributing factor to ENS Mitchell's death. [FF (123-240)]

29. Because of the severity of ENS Mitchell's injuries, I do not assess (b)(6) inability to reach (b)(6) regarding the use of epinephrine as a contributing factor to ENS Mitchell's death. [FF (123-240)]

Recommendations

1. I recommend appropriate disciplinary and administrative action in the case of the Coxswain of RIB BILLY HAMPTON, (b)(6)

2. I recommend appropriate administrative action in the case of the Commanding Officer, (b)(6) (b)(6) the Executive Officer, (b)(6) the Operations Officer, (b)(6) the Training Officer, (b)(6) and (b)(6) Boat Deck Safety Officer and LCPO for Deck Division.

(b)(5)

4. I recommend further study of:

a. The policy of only requiring two crew members per destroyer to attend 7M RIB Coxswain school vice requiring all coxswains to attend the school.

b. The adequacy of current guidelines and publications on how to safely operate a 7M RIB.

c. The adequacy of current guidelines and publications on how passengers safely sit in and hold onto a 7M RIB.

(b)(5)

e. The training conducted on recovering personnel from RIBs and whether or not that should include recovery of personnel via litter.

f. The guidance on when small boat operations are no longer routine and become training events.

The following personnel are recommended for appropriate recognition for their meritorious performance in the aftermath of the incident:

5. (b)(6) – for towing ENS Mitchell back to the RIB without flippers, getting her on board the RIB, and providing immediate medical care to her until her extraction from the RIB.

6. (b)(6) – for relieving (b)(6) from rescuing the other three personnel in the water, caring for them and minimizing their trauma. (b)(6) also unfouled the RIB propeller and preserved ENS Mitchell's lifejacket for review.

7. (b)(6) – for assuming the role of Boat Officer on RIB BILLY HAMPTON and transferring ENS Mitchell to RIB KELLY MILLER.

8. (b)(6) – for immediately responding to the distress call from RIB BILLY HAMPTON and transferring ENS Mitchell to RIB KELLY MILLER and orchestrating her recovery to JASON DUNHAM.

9. (b)(6) – for providing treatment to ENS Mitchell to stabilize her for transport to Aqaba, Jordan.

10. (b)(6) – for providing treatment to ENS Mitchell on board and during the flight to Aqaba, Jordan.

11. (b)(6) – for expeditiously clearing space in Venom 506 for ENS Mitchell and providing medical treatment to ENS Mitchell during the flight to Aqaba, Jordan.

12. Boat Deck Crew and Stretcher bearers – for swiftly bringing ENS Mitchell aboard JASON DUNHAM and getting her to main medical.

(b)(6)

Investigating Officer